# the MODERN HOSPITAL

VOLUME 60 MAY 1943 NUMBER 5

# All May Have *Some* *and* None Goes Thirsty

*A Wartime Message to Gumpert's*
*50,000 Regular* Customers

*By* [signature]
*PRESIDENT,* S. GUMPERT CO., INC.

EVEN though Gumpert ranks first among makers of commercial food products, Gumpert still has only "so much" of each preparation. Certain wartime scarcities and restrictions may mean that some products have to be made in smaller volume this year.

Whatever shortages may affect our products, we are sure of one vital thing: we will maintain Gumpert's famous QUALITY.

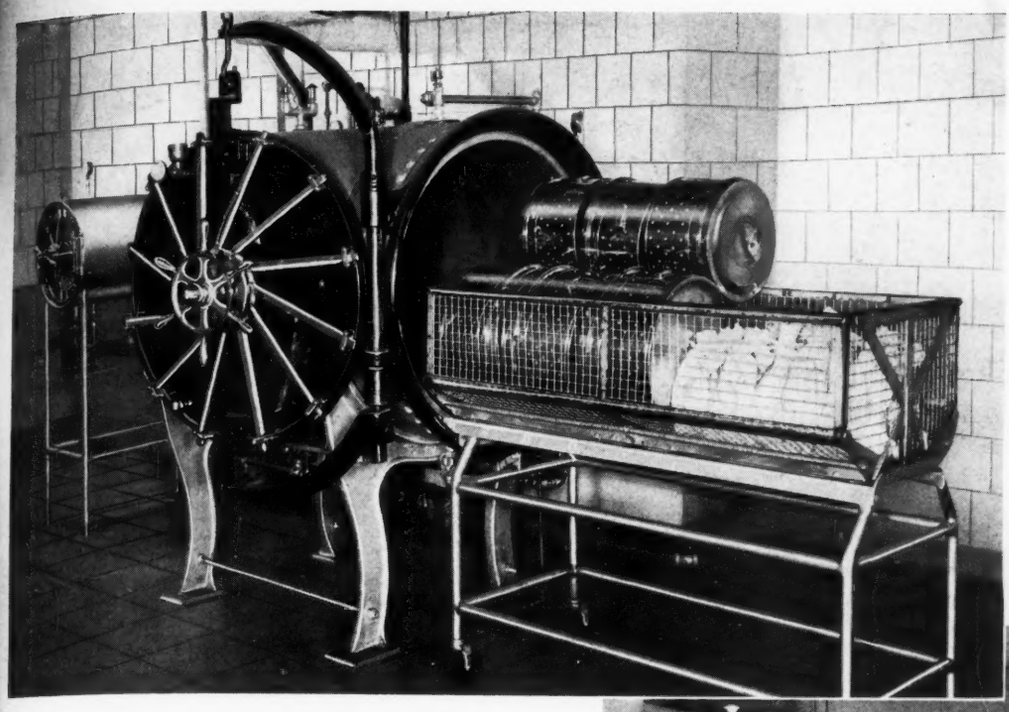
Our policy in the face of any future shortage is to FILL YOUR ORDERS to the utmost of our ability . . . distributing whatever we have *fairly* — so that all may have SOME. At times this may mean a little less for each — but it will also mean 50,000 Gumpert users will be getting as much as, if not more than, ANY other food supplier in the field could provide in wartime.

GUMPERT'S 51ST YEAR

GUMPERTS QUALITY FOOD PRODUCTS

S. GUMPERT CO., Inc.

OZONE PARK NEW YORK



# PLASMA
## *FOR*
## *SAVING LIVES*

From donor to blood bank . . . from blood bank to battlefield goes plasma that saves soldiers' lives.

But the plasma, itself, must be *safe* . . . must be fully protected against contamination.

Sterilization guarantees that protection . . . absolute sterilization—so that plasma is never for one instant imperilled during fulfillment of its life-saving mission.

Here you see a battery of Climax Sterilizers, large and small, operating at a large Red Cross blood bank in New York.

This is but one of many places . . . base hospitals, warships at sea, institutional, industrial and civilian hygienic services . . . in which Climax Sterilizers and Disinfectors are aiding life and health conservation.

Have you a problem? Our 45 years of experienced engineering and our expert advice can help. Write for counsel and complete literature.

# THE HOSPITAL SUPPLY COMPANY

**155 East 23rd Street, New York, N. Y.**

***Since 1898 manufacturers of Climax Sterilizers, Disinfectors, Hospital and Surgical Equipment, Instruments and Supplies.***

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# EDITORIAL BOARD


# Liver Extracts

## LILLY

## *Crude or Concentrated*

ACCORDING to medical history, the first accurate report of a case of pernicious anemia was made in 1822. For more than a century thereafter the disease continued to be almost universally fatal. Arsenic and transfusions were used, but they did little more than postpone the issue. Then in 1925 came the studies of Whipple and Robscheit-Robbins, followed by the work of Minot and Murphy, which soon led to the liver extracts so widely prescribed today. Eli Lilly and Company is proud to have had a part in this development, to have been the first to place liver extract, in any form, at the disposal of physicians.

ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA, U. S. A.

*Lilly*

BUY WAR BONDS AND STAMPS

# THE ROVING REPORTER

## Save Your War Records

The war records of the staff and graduates are worth preserving by all hospitals.

First official notice of the collection of war records for World War II has gone out from Massachusetts General Hospital, Boston. Its Treadwell Library is declared the logical place to compile and house these records by Dr. N. W. Faxon, director of the hospital, but the librarian lacks the time to handle the work. A volunteer worker has been obtained in Mrs. James H. Means.

Mrs. Means has already established a file for letters from staff and graduates, together with other pertinent information, and has started a card file on which will be collected important factual data regarding each person.

Massachusetts General has a fairly complete record of its personnel during World War I.



## "Plant a Row for Us"

"Plant a row of vegetables in your victory garden for the hospital," Children's Hospital of the East Bay, Oakland, Calif., is asking the public.

"We can use lettuce, carrots, tomatoes, beets, artichokes, string beans, squash, spinach and chard. Even small amounts will be useful."

Most amateur gardeners are going to plant vegetables in excess of family needs. This is not a year for waste and if hospitals can arrange to fit small contributions into their menu plans, considerable savings can be effected.

Perhaps some ingenious dietitian can work out a system wherein Tuesdays will be carrot contribution day and Fridays, green beans donation day. Every day in season can be lettuce, radish and onion day.

## Sick-Leave Reduces Turnover

Turnover is less in hospitals that grant sick-time allowances to all types of hospital employes. Two years ago City Hospital, Cleveland, decided to give to all employes the two weeks' sick-time allowance formerly granted only to professional and clerical employes.

Knowing that they could be sick fourteen days in a year without having their pay docked, some employes might be tempted to report illnesses not bona fide, it was suspected.

To prevent such occurrences, George P. Bugbee, the administrator, developed a mimeographed form titled "Request for Sick-Time Allowance." The top section of the form reads as follows:

"I, ....., having been continuously employed at Cleveland City Hospital for one year, do hereby make application for payment to me of my regular salary for the period listed below. I hereby certify that I was unable to report for duty from ..... to ..... because of illness."

The employe signs the form and it has to be approved by his supervisor.

For an illness longer than one day, a medical statement is required. This statement reads as follows:

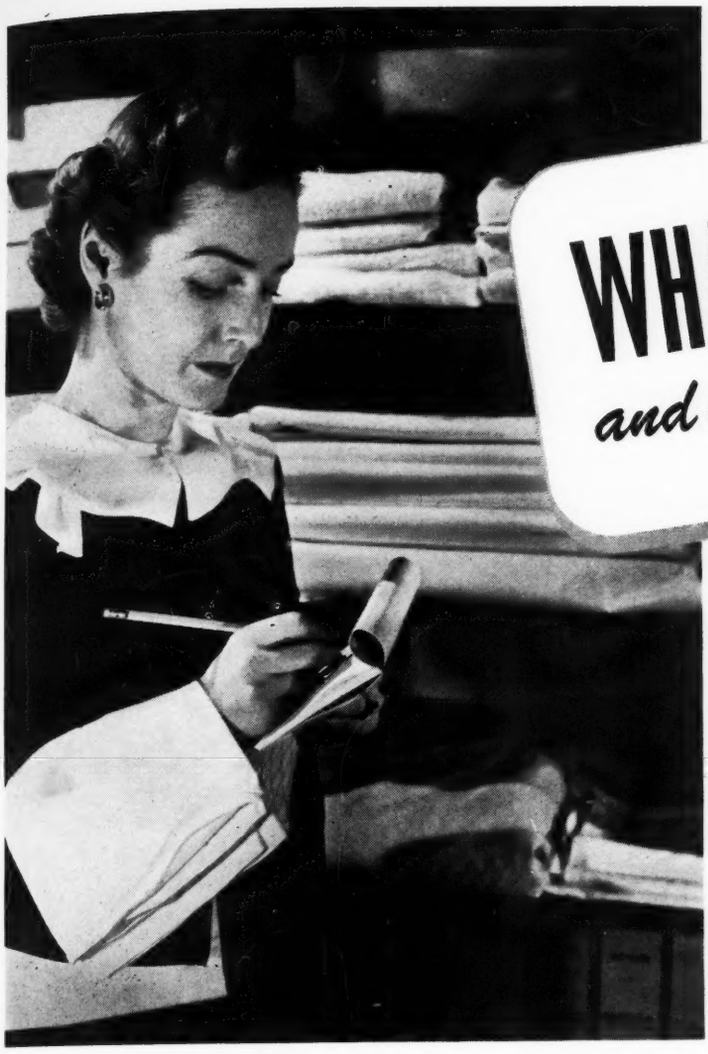
"I, ....., M.D., do hereby certify that ..... was sufficiently incapacitated that I recommended that he/she not report for duty because ....."

The doctor signs his name and address.

The form when filled in must be submitted to the supervisor in ample time to be forwarded to the accounting department with the regular pay roll time sheets.

## Store Explosives Safely

Whether air raids are a probability or a possibility in your locality, you will want to hear about one hospital's new building for the storage of explosives.



# WHAT'S SHORT?

## *and what to do about it*

Shortages in textile supplies are being felt . . . perhaps will be even more pronounced as the war progresses. One man's guess is as good as another's . . . but ours is that conditions will be worse before they are better.

We don't have the answers to all these problems, but

- **We shall continue to obtain and stock all available textile materials, as far as possible**
- **We shall endeavor to meet your requirements, completely and promptly**
- **We shall, whenever possible, secure satisfactory substitute materials for your favorite brands and grades now doing military service**
- **In any case we invite your inquiries and assure you we will do everything we can to help you maintain essential services. It may pay you to write. Address Dept. M5, please.**

### *Textile Specialties*

- Blankets
- Gowns
- Table Linens
- Sheets
- Spreads
- Towels
- Crashes
- Curtains
- Bed Pads
- Infants' Wear
- Rubber Sheeting
- Piece Goods

*John W. Fillman Co., Inc.*

1020-22-24 Filbert St. Philadelphia, Pa.

Located about 25 feet from Lake Wales Hospital, Lake Wales, Fla., is a fireproof, well-ventilated structure. It is only 14 by 17 feet and cost just $740 but it makes the officers of the Lake Wales Hospital Association, Inc., feel much happier in these days of global war for in it are stored alcohol, ether, ethylene, nitrous oxide and other hospital explosives. Supt. Katharine A. Moyer points the new building out proudly to all visitors.

## Funds for Hospital's War

The hospital's war—the war against accident and disease, the ever-present enemies of health and happiness—is dramatized by Missouri Baptist Hospital, St. Louis, in a letter that carries considerable pulling power.

It's a printed letter on the hospital letterhead, which says, in part:

"You are undoubtedly purchasing War Savings Bonds to help your country. . . .

"If you want to help us win our war, may we suggest that gifts to the Missouri Baptist Hospital could be in the form of War Savings Bonds (Series F and G), made out in our name.

"Recognizing the importance of our work, the government permits gifts to us to be included as deductible items from your income tax up to 15 per cent of your net income.

"Thus your money would serve a triple purpose: help win the war, help care for our charity cases and reduce your income tax."

A well-phrased appeal, we think, particularly the clause "recognizing the importance of our work," as if the federal government were thinking particularly of this one hospital. It's a legitimate representation, too, for charitable impulses are strong only when directed toward some specific person or institution.

The mailing date was early March.

## Color Is the Fashion

While dressing up the big wards with fresh paint, Children's Hospital of the East Bay, Oakland, Calif., decided to dress up the patients, too.

Simple washable dresses and suits in gay colors are being provided to take the place of white hospital gowns for small patients who are in the hospital for a long stay.

Bethel Fellowship Group of Bethel Tabernacle is making the girls' frocks, and the young girls who form the Omega Club of Alemeda are buying wash shirts and bright cotton slacks for the boys.

The hospital stipulates that the garments shall be simple cotton ones, easily laundered and with no elaborate trimmings or fastenings to complicate ironing or mending. Within these restrictions the volunteer groups can go the limit in providing colorful and modish clothing.

## Versatility Rewarded

The proudest student nurse at Jefferson Hospital, Philadelphia, each year must be the one who wins the $25 prize for demonstrating the greatest versatility and cooperation in nursing situations. It is an annual award given by the women's board of the hospital. Other prizes go to those with the highest scholastic averages, but on the home fronts and the battle fronts of the world versatility and cooperation plus ingenuity are what count.

## Two Years of Group Insurance

Their first two years under a group life, accident and sickness insurance plan have worked out to the deep satisfaction of employes of Rochester General Hospital, Rochester, N. Y.

Claims paid during the period total $8759, the hospital paying a substantial part of the premiums. New employes are automatically insured after three months' work without medical examination. Twenty per cent of them, on the average, could not pass an insurance examination.

# READER OPINION

## Review of Postwar Planning

Sirs:

After reading through the various articles in the March number, I am impelled to write you further. I am not surprised that Doctor Carter should feel as he does about the old hospitals in view of the terrible experience he must have had with the 18 foot ceilings! I have had to remodel a good many old buildings, including even old private houses, for hospital purposes, but I have never had such a bad case as he had.

I think, however, he is wrong in suggesting that in planning hospitals we should get our inspiration from the temporary buildings we have all seen in Washington, which are thoroughly satisfactory for their purpose. On the other hand, these buildings are in no sense fireproof and, while they might be acceptable for one story buildings, I think the generally accepted requirement that no patients be housed more than 20 feet above ground in nonfireproof buildings would at best limit such construction to two story buildings.

If this form of construction were adopted the deterioration would be far too rapid for the life of one or at most two generations, which was suggested for such construction. With the rising cost for services, I fear that spread-out buildings would cost so much more to operate that this would make up for any savings which might be made in the initial cost of the buildings.

Doctor Carter is quite right in what he says about brick sizes. Here in the New York district we have succeeded in persuading the common brick manufacturers to produce oversize or "jumbo" bricks with most satisfactory results.

Let me express my full sympathy with the ideas as to interior decoration of hospitals as outlined in Mr. Sloan's article. The introduction of washable wallpaper and the realization that curtains may be used on condition that they be kept clean have revolutionized hospital interiors.

Mr. Keck's article seems to set up "straw men" for the pleasure of knocking them down. I do not think that any hospital architect today is wasting money on heavy cornices, towers or domes. Even at Bellevue the architects of one of the later sections expressed to me their regret at being forced to provide a heavy cornice because the particular building was a link between two of the older ones. In reality, the danger would seem to be rather that we may now go to the other extreme and design our hospitals as "machines for living" and forget that, after all, pleasing proportions can be achieved without waste of money.

Miss O'Connor's article on plastics is full of interesting suggestions as to the utilization in hospitals of these astounding new materials.

Let me congratulate you on having published these articles, which are much to the point and obviously tend to produce discussion and, therefore, thought on the part of hospital designers. Since for the moment we cannot build, we can at least occupy ourselves with constructive thinking!

Charles Butler
New York City — Architect

## An Idea Exchange

Sirs:

I appreciate the way in which you have forwarded your journal to me in spite of the fact that I have not been allowed to send you my subscription because of the government regulations. Your journal is a beautiful production containing many interesting and useful articles; it is also an excellent means of enabling the medical profession of this country to gain insight into the organization of hospitals in your country and knowledge of the problems which affect your hospital staffs. Of course, at the present time, many of your suggested solutions to problems, particularly in relation to diet and special equipment, necessitate materials that are not available in this country.

John A. Cholmeley
Moor House
Stanmore
Middlesex, England

## Exchange Administrators

Sirs:

But for the war, I should endeavor to write to you more often and suggest that you may like articles written by a hospital organizer in this country. I have often thought that, but for war conditions, there might have been a possibility for an interchange of hospital personnel by some method which would enable us in this country to spend two or three years in a hospital in America, whilst one of your American organizers could come to one of our large hospitals.

These are matters that we could consider after the war.

Wishing your periodical every possible success.

C. J. Adams
House Governor and Secretary
West Bromwich and District General Hospital
West Bromwich, Staffs, England

# SMALL HOSPITAL QUESTIONS

**Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others**

## Discourage Gratuities

**Question: What attitude should be taken in a private hospital about gifts to employes from patient's relatives?—G.P.S., Ky.**

ANSWER: I am sure that the attitude in general is to discourage gratuities from patients to employes. The type of hospital—private, voluntary or tax supported—should not enter into the picture. Many hospitals have a rule that employes cannot accept gratuities of any type. However, it is almost impossible to enforce this rule. Many others attempt to control this situation by printing in their patient information folders a request that gratuities be omitted.—ROGER DEBUSK, M.D.

## Substitute for China Bristles

**Question: When China or Russian bristle surgeons' scrub brushes are no longer obtainable, what is the best substitute at a moderate price?—A.H.P., Va.**

ANSWER: The supply of China bristle surgeons' scrub brushes appears to be sufficient at this time to meet the supply of hospitals and, unless frozen, will be obtainable for some time. The substitute for China bristles will no doubt be bleached or unbleached tampico fibers. The latter do not have the wearing qualities but are used in many hospitals as they are less expensive.—CHARLES A. WORDELL.

## Orderlies for Small Hospitals?

**Question: How many small hospitals of 50 beds or under employ orderlies, and what salary is paid?—W.E.A., Ill.**

ANSWER: I would say that there are practically no hospitals of under 50 beds that employ orderlies. I do not know what salaries would be paid.—A. F. BRANTON, M.D.

## Discipline Those Doctors

**Question: What can be done when doctors allow case histories to collect and refuse to finish their charts even though given every facility? Every effort has been made over a period of four years to obtain these charts, finished and signed by doctors but without success.—M.F.B., Ont.**

ANSWER: When the hospital has given every facility, such as secretarial help, dictating machines and writing rooms, for the writing of medical records and members of the medical staff still refuse to comply, it is not only the right, but the duty, of the governing body to refuse further hospital privileges to the physician or physicians until such time as they agree to comply with regulations in that respect, adequately and promptly.

Needless to say, if withdrawal of hospital privileges becomes necessary, reappointment to the medical staff should be on probation until it is seen that the agreement to comply with regulations will be faithfully carried out.—MALCOLM T. MACEACHERN, M.D.

## Scheduling Vacations

**Question: What success have hospitals had in offering vacations during the entire year instead of only in the summer months? Has it relieved the problem of obtaining help or are there other problems connected with it?—E.L.K., Minn.**

ANSWER: Adjustments in vacation schedules will have to be made by most hospitals. Spreading vacations over a longer period of time would minimize the number of relief employes required. One institution located in a summer resort town never gives vacations during the summer months. Instead, thirty days off with pay are given during a twelve month period. They can be divided into four one-week vacations or may be taken three or four days at a time. A schedule of this sort would not be practical for most hospitals but it does give one an idea how schedules can be worked out in different localities. I believe, however, that employes should be allowed to take their vacations when it will be of the most benefit to them.—PEARL FISHER.

## Pay for Terminal Vacations

**Question: What is the general consensus about paying graduate nurses for their vacation when they decide to leave the hospital employ about the time the vacations start and request pay for their vacation?—G.S.G., Ohio.**

ANSWER: Questions such as these illustrate the advisability of having well-defined vacation policies and of making clear to each new worker any point that might lead to misunderstanding later. This can be done by having in writing the terms on which vacations are granted and their length. If a vacation is earned, *i.e.* is considered part of the annual salary, the worker is cheated if he is not paid for whatever vacation was agreed upon at the time of his employment even though he is leaving the hospital.

Aside from the moral issue involved, the practice of paying for terminal vacations is good public relations because the worker leaves with a consciousness of having had fair treatment.—ADA BELLE MCCLEERY.

## Other Duties for Receptionist

**Question: In a 25 bed hospital what duties could be combined with those of a receptionist?—J.O., Miss.**

ANSWER: If the budget will allow an additional person as a receptionist, she can be made responsible for the care of the medical records and can assist and relieve the bookkeeper in the office. She can also admit patients to the hospital and relieve the nursing staff by seeing patients to and from their rooms. A person who is not capable of doing these things is probably not qualified to represent the hospital as receptionist.

One small hospital in Michigan found a solution in the use of volunteers from the ladies' auxiliary as receptionists. This helped to improve community relationships through stimulating interest in the auxiliary and also accomplished a valuable service for the hospital. Another hospital has found a partial answer to the problem by employing college students during the periods of the day when a receptionist is most needed.—GRAHAM L. DAVIS.

## Charge for Breakage

**Question: Should a hospital charge for breakage of items by personnel?—C.S.M., Ala.**

ANSWER: Generally speaking, I would say no. However, if it is evident that breakage is excessive because of carelessness, it would be wise to make some charge for it. This will certainly act as a deterrent to those who are inclined to be habitually careless. However, there is nothing quite so annoying as having to pay for breakage that is wholly unintentional and occurs when one has been using reasonable care.—WILLIAM J. DONNELLY.

## Providing Perineal Pads

**Question: What is the number of perineal pads required for a five day obstetrical patient and a ten day patient? Are the pads charged for by the case of five or ten days, or by the dozen? Which is the choice method?—F.K., Calif.**

ANSWER: In Women and Children's Hospital, Chicago, 15 perineal pads are used for each obstetrical patient on the day of their delivery. Thereafter, an average of six pads per day is used for each patient.

For those patients who do not come under a flat rate there is a charge of 50 cents per week for the pads.—EDNA H. NELSON.

# HEADLINE NEWS

MAY 1943

## Hospitals Not Materially Affected by "Hold-the-Line" Executive Order

EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—That President Roosevelt's "hold-the-line" executive order of April 8 does not to date affect hospitals materially on the salary and manpower fronts is the general opinion of Washington officials who have studied the order.

Although the President specifically stated that there was to be no further increase in wages or salaries beyond the Little Steel formula, he excepted such increases as were "clearly necessary to correct substandards of living."

Reasonable adjustments of wages and salaries in case of promotions, reclassifications, merit increases and incentive wages are also permitted provided they do not increase production costs.

The National War Labor Board instructed the regional boards on April 14 that all general orders remain in effect until further notice. General Order No. 26 still holds, according to advice from N.W.L.B. on that same date.

Because *inequities* and *inequalities* can no longer be considered the bases for pay increases under the Little Steel formula, N.W.L.B. must find a definition for *substandard* so far as living conditions are concerned. It has advised the regional boards to proceed "as expeditiously as possible" to make recommendations to the national board on the proper application of the substandards of living provision of the President's order. Public hearings in each region to gather data on the substandards of living issue were suggested.

Concerning provision 3 of the executive order, "forbidding the employment by any employer of any new employe or the acceptance of employment by a new employe . . . ,"—job changing—no one feels sure enough of its effect to make a prediction yet.

On April 17, however, Paul V. McNutt, chairman of the War Manpower Commission, issued regulations that strengthen the President's order. They are virtually the same as those contained in the Baltimore stabilization program (see story on this page). In addition, it is provided that workers who have not been engaged in essential activity in the preceding 30 days may be employed by any employer in an essential activity.

## CMP 5A Can Be Used to Obtain Office Supplies; Order P-29 Revoked

WASHINGTON, D. C.—Office supplies, excluding paper and paper board products, office machinery and equipment, molded pulp products and printed matter, may be obtained with preference ratings assigned under CMP Regulation 5A, according to an interpretation issued April 5.

This means that the ratings assigned by the regulation may be applied to the purchase of such items as staplers, punches, perforators, file fasteners and pencil sharpeners.

Hospitals, however, must not use the AA-1 rating, Everett W. Jones pointed out, until they have made a real effort to obtain delivery without a rating.

Preference ratings assigned by CMP Regulation 5A may be used to obtain *repair parts* for office machinery and equipment, but the regulation specifically prohibits the use of maintenance, repair and operating supply ratings to obtain the machinery and equipment.

For hospitals, CMP 5A replaces P-100, which was revoked April 5. P-29 has likewise been revoked inasmuch as adequate priorities assistance for materials needed in the manufacture of health supplies is now assigned by other means. The Controlled Materials Plan takes care of the allocation of materials to manufacturers.

### Dietitians' Aide Corps Formed

**Washington, D. C.—The Red Cross Volunteer Dietitians' Aide Corps, third of the Red Cross volunteer groups to enter hospital service, received official sanction in Washington, April 12, according to an announcement by Mrs. Dwight Davis, national director, American Red Cross Volunteer Special Services. Details of the qualifications for and duties of the new corps will be found on page 98 of the food service section in this issue.**

## Baltimore Hospitals Inaugurate Labor Stabilizing Program

WASHINGTON, D. C.—Through cooperation with the War Manpower Commission, the hospitals of Baltimore have effected an arrangement that may help them to stabilize their labor force.

This may point the way to similar agreements elsewhere.

Hospitals are classed by the W.M.C. as essential activities but the list of possible hospital employes that are included in essential occupations are only the following: anesthetist, bacteriologist, biologist, chemist, dental hygienist, dental technician, dentist, dietitian, intern, medical technician, nurse, nutritionist, occupational therapist, oculist, oxygen therapy equipment technician, parasitologist, pathologist, pharmacist, physician, podiatrist, surgeon and x-ray technician.

No account is taken of the large number of other workers in the office, food service, housekeeping and engineering departments, except that repair services (building, electric, elevator, engine, gas, heating equipment, industrial and scientific, laundry, machine shop, plumbing, radio, refrigeration and roofing) are called essential activities to the extent and "in such numbers as may be required to meet the minimum essential needs of the community."

Under the terms of the Baltimore agreement, which it is expected will be extended soon to the whole state, the hospitals are required to refrain from employing persons from other war enterprises and from one another and will be

(*Continued on page* 122)

## Cleveland Man Will Be New Managing Editor of Hospitals

John M. Storm, 44, associate editor and chief editorial writer of the Cleveland *News*, has been named managing editor of *Hospitals*. His appointment becomes effective May 1.

Mr. Storm, a native of Nevada, Iowa, has been in newspaper work since 1922. He has been associated with the *News* for sixteen years and has held his present position for the last four years. He is married and has a 7 year old son.

George P. Bugbee, who will also assume his new duties as executive secretary of the A.H.A. on May 1, will serve as editor of the magazine.

## Civilian Physicians to Assist Army in Care of Military Casualties

WASHINGTON, D. C.—Civilian physicians of the affiliated hospital units established by the U. S. Public Health Service and the Office of Civilian Defense have been asked to assist the Army temporarily in caring for military casualties if urgent need should arise in or near the localities in which these physicians reside, the medical division of the Office of Civilian Defense has announced.

The affiliated units of physicians are being organized by selected hospitals and medical schools at the invitation of the U.S.P.H.S. and O.C.D. primarily to provide balanced medical staffs for emergency base hospitals to which casualties and other hospital patients may be removed from casualty receiving hospitals in target cities.

Members receive inactive commissions in the Public Health Service and will be called to active duty by the surgeon general, if the need arises, upon the recommendation of the chief medical officer of the O.C.D.

A unit will be activated by the Surgeon General of the U.S.P.H.S. on the advice of the state chief of Emergency Medical Service to assist the Army, and it will be relieved from active service as soon as the Surgeon General of the Army can assign Army medical officers, the O.C.D. pointed out. Nurses also are to be appointed in the Public Health Service so that they may be available until Army nurses can be assigned.

Army authorities will make all their requests through O.C.D. regional medical officers or through state chiefs of Emergency Medical Service who may have been designated as representatives of the regional medical officers.

Applications for commissions will be accepted only from the following groups: physicians 45 years of age or over, women physicians, physicians of any age who are physically disqualified for military duty and physicians already declared by Procurement and Assignment Service to be essential for civilian needs.

The Surgeon General of the U.S.P.H.S. has already invited 193 hospitals and medical schools to form affiliated units from their staffs. Up to April 19, unit directors had been nominated by 152 of these institutions and 104 had been cleared for commissions. In addition, applications had been received from 397 members of units.

A unit consists of 15 members, including a chief and assistant chief of medical services, two general internists, a chief and assistant chief of surgical services, four general surgeons, two orthopedic surgeons, one dental surgeon, one pathologist and one radiologist.

First in the country to complete a unit was Albany Hospital, Albany, N. Y. Other institutions that had substantially completed the membership of their units on April 15 are as follows:

Newark Beth Israel Hospital, Newark, N. J.; St. Paul's Hospital, Dallas, Tex.; Norwood Hospital, Birmingham, Ala.; Columbia Hospital, Columbia, S. C.; Baylor Hospital, Dallas, Tex.; James M. Jackson Memorial Hospital, Miami, Fla.; Stanford University Medical School, San Francisco; Huntington Memorial Hospital, Pasadena, Calif.; San Joaquin County General Hospital, French Camp, Calif.; Syracuse University College of Medicine, Syracuse, N. Y.; Jewish Hospital of Brooklyn, N. Y.; Eastern Maine General Hospital, Bangor, Me.; Methodist Hospital, Dallas, Tex.; Lynchburg General Hospital, Lynchburg, Va.; Springfield Hospital, Springfield, Mass.; Maine General Hospital, Portland, Me.; Central Maine General Hospital, Lewiston, Me.; Newark City Hospital, Newark, N. J.; Atlantic City Hospital, Atlantic City, N. J.; City-County Hospital, El Paso, Tex., and University of California Medical School, San Francisco.

## Student War Nursing Reserve Bill Introduced in House and Senate

WASHINGTON, D. C.—A bill to provide for a Student War Nursing Reserve (the new name for the Victory Student Nursing Corps) was introduced in the House of Representatives on March 29 by Mrs. Chester C. Bolton of Cleveland, long-time champion of nursing in the United States, and was later introduced in the Senate by Senator Bailey of North Carolina.

Under the bill it is proposed that all student nurses in approved schools enrolled since Jan. 1, 1941, be eligible for enlistment in the proposed reserve; that they promise to make their services available after graduation for the armed forces or for civilian nursing work essential to the war effort for the duration and six months thereafter; that tuition and a small monthly stipend be paid to such enrolled students, and that the schools of nursing speed up the period of training to twenty-four or thirty months.

The Student War Nursing Reserve is to be established in the U. S. Public Health Service and its members classified as "junior grade," "senior grade" and "cadet" with a distinctive insignia and street uniform.

The bill also authorizes appropriations for refresher and postgraduate nursing courses, a continuation of the program carried on in the fiscal years 1942 and 1943.

The estimated costs of the program indicate that the U.S.P.H.S. will pay about $45 per month for the maintenance of these students for the first nine months, while the school or hospital will provide maintenance for the remainder of the period.

Stipends for students are $15 per month for the nine months preclinical period, $20 per month during the period of training and practical work and $30 per month for the cadet period. These stipends are paid by the U.S.P.H.S. during training and by the hospitals during the cadet period.

In addition, the federal government proposes to meet the instructional costs to the extent of about $250 per student for the entire period and the costs of uniforms, books and similar equipment to the extent of about $140 per student. These figures are for the twenty-four month curriculum; there are slight changes for the thirty month program.

The hospital will not only provide maintenance after the first nine months but will also provide clinical supervision, clerical services and classroom facilities.

It is estimated that for the twenty-four month curriculum the total cost of preparing 100 nurses will be $3169 per nurse, of which the U.S.P.H.S. will pay $1230 and the hospital or school will pay $1939. For the thirty month curriculum the figures are: total, $3059; cost to U.S.P.H.S., $1250, and cost to school or hospital, $1809.

### PD-1A Forms Go to Washington

WASHINGTON, D. C.—All PD-1A applications for hospital capital equipment will be processed in Washington, *not* in the field, Everett W. Jones said in a recent interview. If an applicant wishes to file his PD-1A form with the regional or district office for the purpose of checking as to its accuracy he may do so, but the regional or district office must send the application for processing to the hospital section, Governmental Division, W.P.B., in Washington.

### CMP 5A Usable for Power Plants

WASHINGTON, D. C.—Although the high ratings granted by CMP 5A, as reported in The MODERN HOSPITAL for April, are not available for central light, heat and power plants, these ratings can be used for the individual power generating or steam generating plant in an individual institution, according to a letter of March 31 from Everett W. Jones, head hospital consultant, W.P.B.

## Grant for Field Work Given Nursing Council by Kellogg Foundation

A grant of funds for field service has been made to the National Nursing Council for War Service by the W. K. Kellogg Foundation to help schools of nursing accelerate their basic educational programs.

The program of field consultation in the states that request it was scheduled to begin in April and will extend up to the time of the annual meeting of the National League of Nursing Education in June, it was announced by Anna D. Wolf, R.N., field service chairman.

The director of the field service is Helen G. Schwarz, R.N., now on leave of absence from her position as dean of the College of Nursing and Health, University of Cincinnati, and director of nursing, Cincinnati General Hospital.

Field consultants who will assist with conferences are: Sister M. Ancina, educational director, St. Mary's Hospital, Rochester, Minn., and College of St. Theresa; Anne L. Austin, professor of nursing, Frances Payne Bolton School of Nursing, Cleveland; Mary Brackett, New York State Board of Nurse Examiners; Lucile Petry and Eugenia K. Spalding, senior consultants, U.S.P.H.S.; E. Louise Grant, dean of the school of nursing, Medical College of Virginia; Olga Breihan, educational director, Baylor University Hospital; Mildred Lorentz, director, school of nursing, Allegheny General Hospital, Pittsburgh; Lulu K. Wolf, professor of nursing education, Vanderbilt University, and Kathleen Leahy, University of Washington.

## Oregon Plan Reaches Year's Quota Within First Quarter

The Northwest Hospital Service Plan of Portland, Ore., became the first Blue Cross plan in the country to reach its 1943 enrollment goal, when on April 1 it reported a first quarter growth of 18,602, bringing its total enrollment beyond the 50,000 quota set by the American Hospital Association.

According to reports from the Hospital Service Plan Commission, the Oregon plan was way out in front. M. F. Bradley is the Oregon director.

The total enrollment in all 77 approved Blue Cross plans on April 1 was 11,012,602, an increase of 553,703 since January 1. The 10 plans with the largest growth during the quarter are: Newark, N. J., 47,959; Cincinnati, 36,836; Pittsburgh, 31,562; Boston, 30,714; St. Paul, 28,373; Toronto, 25,920; Philadelphia, 22,196; Chicago, 21,024; Portland, Ore., 18,602, and Detroit, 16,504.

# Nurse Recruitment Given Top Priority on Publicity in May by O.W.I.

WASHINGTON, D. C.—An intensive recruitment campaign to enlist 65,000 new student nurses to join this year's June classes was started in April and will be carried forward with increased vigor during May, according to nursing authorities.

While 65,000 new student nurses is the goal for all of 1943, it is expected that most of them must be enrolled in June and September classes.

The program of intense public education has been prepared by the Office of War Information with the cooperation of the subcommittee on nursing of the Health and Medical Committee of O.D.H.W.S. The National Nursing Council for War Service is also cooperating closely.

The government program, which was outlined in a pamphlet issued early in April by O.W.I., is aimed at "Mary Jones," who will be graduated from high school this spring.

"In spite of all efforts, enlistment fell 11 per cent short of the 55,000 goal set for 1942 and there is great danger that unless strenuous steps are taken, we shall miss the 1943 goal by an even greater margin," the pamphlet declares. "During the spring and summer months, nursing must be overemphasized if we expect to relieve the nursing shortage."

The Retailers War Campaigns Committee, in cooperation with O.W.I., has made student nursing a No. 1 project for its April and May promotion in approximately 150,000 retail stores. Many stores are setting up student nursing information booths, arranging meetings and lectures and featuring nursing in advertising and displays, in cooperation with the local nursing councils for war service.

## National Hospital Day Programs to Feature Nurse Recruitment

Extensive radio programs on national hookups and heavy plugging for nurse recruitment are the two outstanding features of the 1943 National Hospital Day observance as developed by the A.H.A. council on public education.

In addition to many local programs, the following network broadcasts are scheduled for May 12:

12-12:15 p.m. E.W.T.—Blue—"Meet Your Neighbor" program. Alma Kitchell will interview John Hayes, superintendent, Lenox Hill Hospital, New York City.

3-3:45 p.m. E.W.T.—Blue—"Between the Bookends" program. Ted Malone will interview Dr. Paul Keller, medical director, Associated Hospital Service of New York.

5:15-5:30 p.m. E.W.T.—C.B.S.—Dr. Robin C. Buerki and Florence Seder will discuss "Careers in Nursing."

6-6:15 p.m. E.W.T.—N.B.C.—James A. Hamilton and Congresswoman Frances P. Bolton of Ohio will tell a student nurse applicant about present day nursing.

Thousands of nurse recruitment folders entitled "Nurses Are Front Line Fighters" are being distributed by Blue Cross plans directly, through member hospitals and through the state and local branches of the National Nursing Council for War Service.

Awards this year will be made on the basis of the best year-round program of public education ending with the observance on May 12. The awards committee consists of R. F. Cahalane, chairman, Rev. John J. Bingham and Dr. R. H. Bishop. The National Hospital Day advisory group and the liaison group will work with the awards committee.

## Put Idle Motors, Generators Into Service, Gammell Urges

WASHINGTON, D. C.—Every idle electric motor and generator should be put back into active service inasmuch as restrictions on purchase orders for new equipment imposed by General Conservation Order L-221, as amended January 15, are designed to ensure full use of secondhand equipment, it was stated on April 10 by John Gammell, chief, electrical equipment branch, W.P.B.

A purchase order for new motors or generators must have a preference rating of AA-5 or higher and the prospective buyer must certify that he has made every effort (1) to adapt idle motors or generators in his possession to the purpose for which new ones are sought; (2) to obtain used equipment from other sources, and (3) to repair or recondition his existing equipment.

A Used Motor Unit has been set up by the electrical equipment branch to assist industry in locating idle motors and generators, Mr. Gammell stated. This unit has a file, which covers the country, of about 30,000 used motors and generators and serves as a clearing house for owners and prospective buyers.

## Food Rationing Rules Relaxed; Further Help to Be Given Hospitals

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—In an exclusive interview on April 23, Archie Palmer, deputy chief, food rationing division, O.P.A., announced one important change in food rationing procedures for hospitals and stated that other amendments to the order are being worked out. He assured hospitals that their needs will be given every consideration and urged them to be patient.

"Our efforts to work out solutions to the difficult problems of hospitals are seriously hampered by insistent pleas and unjust criticism," he said. Twice during the week of April 19 he held hearings and listened to specific recommendations from hospital representatives carefully selected for their intimate knowledge of hospital problems.

The change made on April 21 by Amendment 14 to General Ration Order 5 permits the hospital superintendent or other executive officer in charge, whether or not he is a physician, to sign the application for a supplementary allotment.

The following changes are now under consideration: (1) an amendment to increase the per person allowance of processed food for patients but not for personnel; (2) an adjustment on inventories to take account of the fact that while some processed foods that were originally rationed are now off the rationed list, yet hospitals were charged with their point inventory at the time of registration; (3) an adjustment of the meats and fat rationing program to meet the essential needs of hospitals; (4) a proposal from hospitals that patients' ration books not be collected until the fourteenth or twenty-first day (instead of the seventh day as under present rules); (5) a proposal from hospitals that they deduct from the ration books of resident employes only the number of stamps commensurate with the actual meals eaten, thus leaving some stamps for the employe to turn over to his family when he eats at home.

Mr. Palmer stated that December 1942 will be kept as the base month for determining ration needs. If, however, that month was not normal, a hospital may petition its local rationing board to have its base adjusted according to General Ration Order 5, Section 12.2 and Amendment 12.

Hospitals were advised to develop a home canning program, using volunteers as well as regular personnel. No ration points will be charged for home canned foods.

## O.W.I. Report on Physician Shortage Provokes Disagreement With A.M.A.

WASHINGTON, D. C.—Considerable disagreement as to the seriousness of the present shortage of physicians appeared last month between the Office of War Information and the American Medical Association.

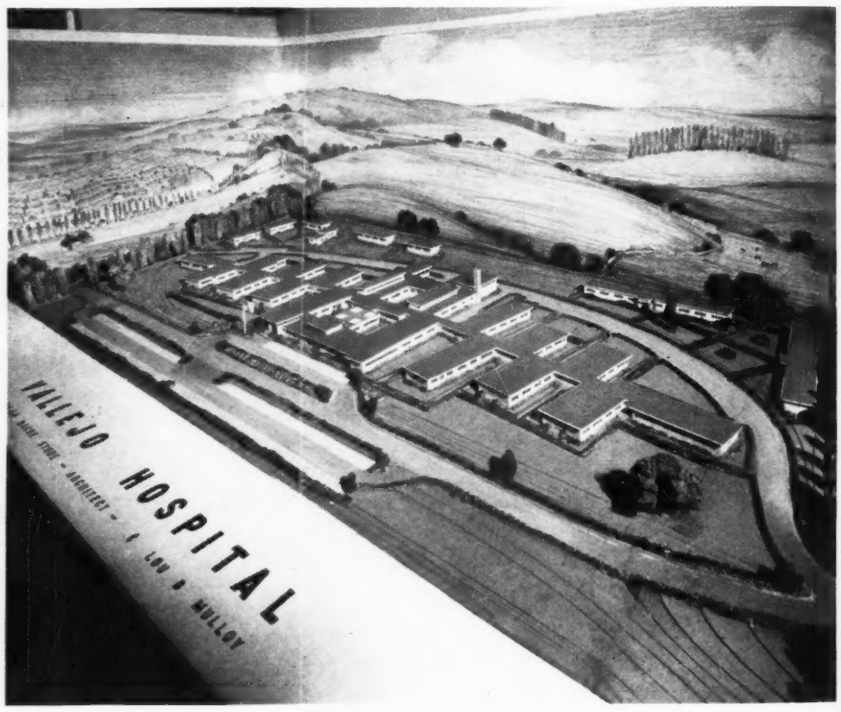
On March 29, O.W.I. released the results of a survey of the subject in some 60 communities in 20 states in which shortages of doctors have been reported. Representatives covered farming communities, small towns that have mushroomed because of war industries and large cities.

O.W.I. found that so far the health of the nation has not been seriously impaired by the doctor shortage. But "doctors are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health."

Likewise, while the number of communities critically in need of doctors is not large, those in need are among those "most vital to our war program. . . . In too many cases physicians were recruited for the armed forces without sufficient regard for the welfare of the civilian population. There are enough doctors remaining in civilian practice to give adequate care to the civilian population provided they can be properly distributed numerically and according to special abilities."

The voluntary relocation of physicians, however, has proved extremely difficult and has not resulted in a solution to the problem, O.W.I. declared. In some communities local medical groups have resisted attempts to relocate outside doctors.

In answer to this survey, the *J.A.M.A.* for April 3 stated editorially that "frequently throughout the release isolated or remote communities are cited with low physician-population ratios and given as evidence of the breakdown of Procurement and Assignment Service. Upon closer inspection it becomes evident that many of these communities did not have more favorable ratios prior to the war."




**Model of the 262 bed hospital designed to serve the war-expanded community of Vallejo, Calif., for which ground was broken on April 5. The institution, located a mile north of the town, is being constructed by the emergency operations unit of the public buildings administration of F.W.A. It will have an emergency capacity of 300 or 350 beds. Buildings will be entirely of one story wood construction, with fire walls between corridors to prevent the spread of fire. Two nurses' homes and two buildings to house 40 other employes will also be constructed on the 20 acre site of the institution. The project will cost $1,100,000.**

# LOOKING FORWARD

## For National Hospital Day

AN EVENT that took place in New York City during the past month deserves more than passing notice. On March 29 and 30 hundreds of men and women took time from their already overcrowded schedules to attend a symposium on civilian hospitals in war time. For two evenings and one afternoon in the ballroom of the Waldorf-Astoria they listened to a program arranged by the United Hospital Fund of New York in cooperation with the Greater New York Hospital Association and the New York Academy of Medicine, details of which will be found on another page.

This did not signal another hospital drive; there were no obligations other than to sit and to learn of a situation that affects the health of every man, woman and child in the community. The response was gratifying. New York rallied to the hospital cause.

As we approach the observation of another National Hospital Day, the idea of a public hospital rally is something to conjure with. Whether this takes place in New York's Waldorf-Astoria or in Speedunk's Town Hall, the opportunities are the same. What matter if the program does not include national figures so long as someone is available who can tell the hospital story clearly and accurately! What could be more effective, for example, than a nurses' aide's interpretation of hospital service and needs?

The unprecedented demand upon hospital facilities, coupled with lack of manpower, may not make it expedient in war time for such hospitals to throw open their doors to large numbers of visitors. But this does not mean that they cannot celebrate most appropriately elsewhere—anywhere an audience can be assembled. The National Hospital Day celebration in war time can be made as effective, even if it is different, as those of preceding years. The United Hospital Fund of New York has indicated one way.

## Hope Springeth—

HOSPITAL administrators in all parts of the country may well sigh with relief over the announcement in The MODERN HOSPITAL last month that Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N. Y., had accepted a commission as a lieutenant-colonel in the U. S. Army Medical Corps to study the military hospitals in this country. The relief comes not from the fact that Doctor MacLean is in the Army, for his wise and pungent counsel will be sorely missed, but rather from the nature of his assignment. According to the announcement from the University of Rochester, the "purpose of his survey is to determine whether the nation's military medical personnel is being used to the best advantage. He will report his findings to the surgeon general of the Army."

In requesting Doctor MacLean's services, Maj.-Gen. James C. Magee, the surgeon general, pointed out that the Army is operating the largest hospital service in the United States, that it has grown rapidly and is still expanding and that while the organization and administration are excellent "some improvements may be made."

General Magee states that the medical department desires to provide the American soldier with the most efficient service that it is possible to obtain. With this view all of us agree wholeheartedly.

Since, however, Britain and other warring nations likewise may be presumed to have the same desire, Doctor MacLean's assignment may well include a full inquiry into methods that permit other countries to provide medical service to their soldiers with a much lower ration of physicians to soldiers. If Doctor MacLean is able, on the basis of his studies, to suggest practical methods of economizing on the time of Army physicians, nurses and other skilled personnel, the civilian population will be greatly in his debt.

If, on the other hand, he determines that no substantial reductions in the present ratios can be effected without seriously jeopardizing the welfare and safety of American soldiers, Doctor MacLean's prestige in the hospital field is so great that his conclusions will be accepted. We will merely tighten our belts and get along with the available supply of health workers.

The surgeon general is to be congratulated for having chosen the best available man for this important job.

## Food Rationing Headaches

WHEN the "arsenal of democracy" undertakes to feed its own armed forces and allies in all parts of the globe, it is little wonder that the supply of food soon begins to run short at home. So, in fairness to all, food rationing must be undertaken. This is an expense and an added harassment to hospital administrators and dietitians. Some fumbling and maladministration are bound to creep into such a gigantic program.

Any of us who are inclined to let our annoyance

get out of hand, however, could well spend a few minutes reading again the stories that came out of Stalingrad. The magnificent heroism of the Red armies has been fully matched by the stupendous courage and tenacity of the civilian population that supports them. Living in caves and cellars for months on a small and uncertain food supply, the population of Stalingrad would probably find it incomprehensible that Americans should grumble at their relatively generous food allotments.

Hospital administrators, like other patriotic citizens, will not complain at any restrictions in food that are found necessary. We have no right, nor do we wish, to request special favors for ourselves and our employes. We'll take food cuts the same as the rest of the population and, like it, make a joke of the resulting economies.

We do, however, ask for special consideration for our patients. Proper food is part of our therapy and helps to restore patients to health and productiveness. We also ask, in all reasonableness, that our heavily burdened dietitians be no longer required to stand in line for hours at the local rationing boards and, even then, sometimes be treated discourteously and have their proper requests refused or unduly postponed.

Furthermore, we strenuously object to the fact that hospitals are put in the same category as night clubs and roadhouses! Such a classification indicates a complete lack of understanding of our true function and place in society.

Top O.P.A. officials in Washington have been receptive to the pleas of hospitals and doubtless our problems will be worked out in time. The appointment of a qualified hospital administrator to take over the hospital aspect of the rationing problem, an appointment which has been imminent for the last two months, should go far to solve these vexatious problems.

## Who Can Replace the Millionaire?

IN DISCUSSIONS of the future of voluntary hospitals, much loose thinking and looser talk have swirled around the prospective extinction of large givers. They are, according to the more gloomy prophets, soon to rank with the dodo. As a result, hospitals will no longer receive gifts of one million dollars or more from generous or penitent men of wealth or from their widows. And when hospitals can't expect such gifts, the future rocks with dire uncertainty.

Before yielding to such a fate, let us analyze the situation a little more realistically. In the first place, not all of the capital investment in voluntary hospitals has come from the wealthy classes. There are many voluntary hospitals doing good community service jobs that have never in their history had a gift of $100,000. When they needed to expand they raised as much money as they could in small contributions and borrowed the rest from a bank or insurance company, paying it back in a reasonable period out of earnings. Some of them, it is true, were seriously embarrassed when the 1929 depression hit them. They had borrowed too heavily. But, actually, few voluntary hospitals went out of business during that prolonged depression. So the technic used by these hospitals still remains.

It is true that taxation policies will make it much more difficult to accumulate excessively large fortunes in the future. But along with those policies have come other policies that spell higher incomes for thousands of people. Properly approached and cultivated, the owners of these incomes can be won as supporters of voluntary hospitals. While their individual gifts will be small, the total can be substantial.

Finally, it is possible for hospitals frankly to add capital costs to their regular charges. Even for an investment per bed of $6000, the capital charge per patient day is 50 cents or less. This is not an impossible load to place on regular charges. Governmental agencies that pay for hospital service, Blue Cross plans and just ordinary patients would probably accept such an increase without complaint.

If hospitals follow this procedure, they should carry out the responsibilities as well as reap the benefits. The funds collected should be put into a separate trust for the purpose of replacing buildings and equipment as they wear out. Right now would be an excellent time to start such a trust fund.

## Men Volunteers

IMPELLED by the interest of their wives and daughters in hospital work, increasing numbers of public-spirited men are following suit and volunteering their services. "If the women can do it, why can't we?" is an argument with which no hospital administrator will take issue; instead, he will proceed to find logical places for such willing hands.

A recent check-up reveals training programs for amateur orderlies, comprising ten or fifteen hours during which the registrant is instructed in moving patients to and from the operating room and in certain simple procedures in bedside care, including the setting up of Balkan frames. In addition, public-spirited citizens are running elevators, driving ambulances, performing clerical and other administrative duties and even acting as watchmen. One institution boasts an architect, a lawyer and a banker among its most loyal workers, and a community interest so great that several industrial concerns are granting time off during the day to younger executives who are willing to give their services.

What greater assurance can the harrassed hospital administrator have than the knowledge that the public recognizes the urgency of the situation and is ready to roll up its sleeves to help! It makes even the problems of volunteer training and management seem small in comparison.

# The PERSONNEL Problem *must be put on a* PERSONAL Basis

**SALLIE JEFFRIES**
DIRECTOR OF NURSING
U. S. DEPARTMENT OF THE INTERIOR
OFFICE OF INDIAN AFFAIRS
CHICAGO

HOSPITAL personnel relationships differ little from those in any well-organized office or business. Those engaged in the medical and nursing professions should have acquired knowledge and understanding of human nature and thus be able to assist in harmonizing relationships. This, unfortunately, is not always the case.

Much more might be done in the early elimination of misfits in the medical and nursing schools through a greater awareness on the part of the faculty as to what constitutes a good personality for the profession. Many of the more progressive schools are trying to meet this need through the establishment of guidance programs and, in some instances, schools are working on the problem of personality development.

Emphasis is being placed on the importance of selecting certain types of personality and moral integrity for nursing schools. This is illustrated by the recent "Vocational Division Leaflet" on nursing published by the U. S. Office of Education.

### Human Effort Is Wasted

Personnel management often has been directed more to the mechanical than to the psychological aspects. Employes are frequently selected for hospitals with little regard to the suitability of the individual's personality or ability to perform. If hospital equipment and material were wantonly wasted, immediate investigation would follow. There is no such concern over waste in human effort.

The human side of the organization is its most vital force. Without the interest and loyalty of the employes no hospital contributes its best to the patient and community. Such interest and loyalty depend to a large extent upon efficient organization, wise planning and sympathetic supervision by the hospital administrators. Broad and well-defined plans, *consistent decisions* and fair and just administrative attitudes are bound to be reflected in the attitude of the employe.

Of these, the most immediate important effect on the employe is the consistency of the pattern.

A prerequisite of sound personnel management is the study and analysis of the work to be done. To obtain the sympathy and cooperation of the employes, a careful explanation should be made as to why and how such a study is to be made. The staff should be invited to cooperate, offering suggestions on the basis of its experience. An analysis of a job is really an outline of the duties to be performed, their arrangement in consecutive order and the collection of data that will help in writing job specifications.

Properly made and scientifically used, such an analysis will reveal many correctible defects, such as faulty arrangement, poor layout of departments and overlapping or duplication of work. It will also assist in a better adjustment of the employe to his individual job. The analysis may be used to: (1) place responsibility; (2) revise work plans; (3) place personnel more wisely; (4) assign duties more judiciously; (5) acquire knowledge of employe's ability; (6) develop economies in time and effort, and (7) conserve funds.

After an analysis has been made, a graphic chart to be displayed in each department should be prepared showing the position of each worker in the hospital and the relationship it bears to other positions. This is indispensable to good hospital management, regardless of the size of the institution, and should do much to eliminate confusion and misunderstandings from poorly defined duties and responsibilities. Each employe needs to know his place in the organization. As in industry, it is important that a worker have knowledge of the duties of three jobs—the one he is doing and the ones above and below him. Every effort should be made to create an atmosphere in which every employe is given a feeling of being important.

Esprit de corps is present only when each person feels that he is receiving fair and equal treatment. These are the main factors in determining that feeling:

1. Salary that bears a direct relationship to responsibilities carried.
2. Good working conditions.
3. Comfortable quarters and good food.
4. Opportunity for growth or self-expression.
5. Opportunity for promotion.
6. Opportunity for recreation.
7. Wise and considerate leadership.
8. Emotional maturity.

### Leadership Is Overlooked

Most institutions appreciate the importance of the first six factors. The significance of leadership is often ignored. Yet the integration of the entire organization depends on leadership. Those in charge of employes may not be fully aware of their responsibility to them as human beings. They have the potential ability to "make or mar, the opportunity to build or tear down, the chance to stimulate or discourage, the power for good or evil." The growth of the employe may depend on the department head's vision and understanding of human nature. These are essential requisites for successful

personnel management. The democratic spirit, which recognizes the need for intelligent direction, should prevail. It does not countenance dogmatic tyranny or servility.

The administrator, instructor or supervisor must possess a knowledge of methods of and interest in promoting understanding. A large share of the following personality qualities is required in order to be successful:

1. Imagination.
2. Judgment.
3. Sympathy, with *a liking for human beings.*
4. Emotional maturity.
5. Honesty.
6. Courtesy.
7. Patience.
8. Tolerance.
9. Ability to see and assist in developing the best potentialities in the employe.
10. Ability to work with others.
11. Ability to command the respect of others.
12. Appreciation of standards and methods.
13. Approachableness.
14. Unselfishness.

### Employe Conferences Help

Staff education should be arranged not only for the administrative staff, physicians and nurses but for all hospital employes. There should also be occasional conferences that include every member of the institution.

The plan for staff education should include discussions of normal and abnormal behavior patterns and the methods of approach to the diversity of personalities found in any group. Active participation of each member should be encouraged. Self-improvement upon the part of each staff member should be the objective of these conferences and an effort should be made to arouse in each individual an interest of self-evaluation.

The best results in self-development are achieved by "taking stock of one's self" if one is able to view his own attributes impartially. Through practice and habit one may acquire a desirable trait that is not inherent.

1. Avoid criticizing one employe to another. It takes no more than average intelligence to know that if one is disloyal to a fellow employe the same tactics will be practiced in relation to the confidant.

2. Be generous in giving credit where it is due. Never try to steal another's ideas or accomplishments.

3. Let someone else note your accomplishments; do not yourself call them to attention.

4. Make allowance for unfavorable behavior and try to find the cause. The knowledge may condone the fault.

5. Avoid constant faultfinding. The habit is so easily acquired and so difficult to break.

6. If you have been in a situation where there was friction, try to determine where you as well as the other fellow may have been at fault. This takes unusual ability and fortunate is the possessor. Such an individual learns and grows in each experience and his knowledge of human nature is broadened.

7. If an error is made, do not rationalize it, but frankly admit it. This does much to mitigate the mistake, and also it is much sooner forgotten.

8. Give the other fellow a chance to display his wares even if it means not displaying one's own.

9. Remember that spoken judgments are ineffaceable and have much potentiality for good or evil. Although they may not be true, the doubt is raised, and one has little difficulty in finding behavior for which he is looking.

A satisfactory staff cannot be built if the principal claim to advancement is that of length of service. (It should count if other things are equal.) Nor can the sole criterion be the possession of a degree.

### Do You Have These Traits?

Any hospital employe endowed with an analytical and objective attitude might find it worth while to check the following questions:

1. Are you loyal to the organization and to your officers? Loyalty gives you respect for and belief in the policies of the hospital administration.

2. Do you use the pronoun "I" frequently in speech and in writing? It may tend to create the impression that you are an egotist. No one can exhibit an excellent opinion of himself and hope to attract many followers.

3. Do you try to find the motivation for unsatisfactory behavior? If so, you have understanding based on adequate knowledge.

4. Can you keep the confidence of others? You may at times be entrusted with personal information about an individual. If you discussed it with another, do you think he would wish to consult you concerning his own problems?

5. Are you impartial in your favors and your relations with the staff? Employes are sensitive to the degrees of favor shown. Their resentment is not only for the one responsible but also for the individual favored.

6. Do you reflect an attitude of disapproval instead of frankly telling the individual what is wrong? This does not give the employe the opportunity to meet the issue as he can only guess the cause.

7. If it is necessary to correct an individual, do you keep it a confidential matter unless it is necessary to call in higher authority?

8. Do you refrain from and discourage gossip at all times?

9. Are you sarcastic? Cleverness at someone's expense is not good social behavior.

### Don't Show "Authority"

10. Do you tolerate differences of opinion? The dominating type is suggested by the Irishman who said, "It isn't that I hate you that I bate you, it is to show my authority."

11. Do you cultivate an individual because he may be able to do something for you? This trait has long been recognized and the derogatory names describing it are many.

12. Do you try to know and understand your associates? Do you encourage them to tell of their hobbies, interests and ambitions? This would do much to make you like them.

13. Do you cultivate finding the good in those with whom you associate? If you do, you will find their attitudes will reflect your good opinion.

14. Do you take offense? Are you easily hurt? The sensitive person frequently is least considerate of the feelings of others and touchiness is often due to a sense of inferiority. Polk implied this when he said, "Those best can bear reproof who merit praise."

It is realized that behavior is motivated by various reasons. E. J. Benge says, "Acts of consciousness are readily divisible into two main classes: (1) intellectual acts; (2) emotional

acts." The intellectual arguments usually fail with the average individual to offer sufficient motivation, whereas the emotional reason stimulates the worker to his best production level. Therefore, the emotional side of the employe is more important. We think of adults in terms of age, physique, intellect or reason. Perhaps the most important factor in making life satisfactory is a full emotional development or emotional maturity.

Sanity depends more upon emotional maturity than upon any other one thing. The day may dawn when an organized system will be available that will enable us to educate our emotions. Many psychological frontiers have yet to be discovered. This fact offers a great challenge to those who are interested in finding the best way to deal with diverse personalities.

When we fully understand ourselves and others, there will be little opportunity for misunderstanding. This is a millennium we are far from realizing but a goal to which we may all aspire.

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# New York Hospitals Rally to Meet the IMPACT of WAR

**RAYMOND P. SLOAN**

LARGE audiences gathered in New York City on March 29 and 30 to learn at first hand some of the problems affecting civilian hospitals in war time. Three sessions, two in the evening and one in the afternoon, held at the Waldorf-Astoria by the United Hospital Fund in cooperation with the Greater New York Hospital Association and the New York Academy of Medicine revealed the seriousness of the situation produced by a shortage of doctors, nurses, personnel and supplies and pointed to new responsibilities in the future. The purpose of the gathering, in the words of Roy E. Larsen, president of the fund, was "to evaluate the impact of war on our hospitals, on our special medical services and on our medicine in the home."

The most pressing health problem of the moment, in the opinion of Dr. Harvey B. Stone, professor of clinical surgery, Johns Hopkins Medical School, and member of the directing board, Procurement and Assignment Service, is the reallocation of physicians and dentists to care for the "scarcity areas" of civilian need. This is being carefully studied by the U. S. Public Health Service in conjunction with the Procurement and Assignment Service.

It is Doctor Stone's opinion that with wise planning and the sincere efforts of all interests to keep demands limited to the necessary rather than expanded to the ideal, we shall come through without grave distress or serious danger.

"All hospitals," Doctor Stone stated, "are requested to reduce their resident staffs to the minimum consistent with safety. As a working rule it is suggested that this be approximately 50 per cent of the number carried as of July 1941 with the understanding that special circumstances may modify the rule somewhat in either direction. Then it is requested that the reduced number of resident positions be filled as much as possible by women, by the physically handicapped and by others not eligible for commissions.

"Having taken those measures, in all good faith, if a hospital still finds itself unable to fill the minimum essential number of resident positions it may proceed as follows: It may request permission from the state chairman of the Procurement and Assignment Service to fill the vacant positions with young men who would otherwise be eligible for commissions or who as interns may hold commissions but are not yet ordered to active duty.

"The state chairman, after assuring himself of the facts, and if he agrees, will forward the request through the central board to the Army or Navy authorities with his endorsement. These authorities, in turn, have agreed, under such circumstances, to arrange for the deferment from active duty of a limited number of young men for a period of twelve months."

The place of the practical nurse must be given careful consideration in viewing the nursing situation. Granted proper preparation she will furnish an excellent solution for certain problems, according to Margaret E. Conrad, director of nursing, Presbyterian Hospital, and professor of nursing at Columbia University. Leadership in working out zones of activities for the practical nurse should come, she believes, from the nursing profession as it has in the case of the Red Cross volunteer nurses' aide. Protection of the patient demands some type of certificate of competency for the person who offers her services as a practical nurse.

Several of the speakers touched upon the future of hospital and medical service. Waldemar Kaempffert, science editor, *New York Times,* sees the day of the private practitioner as passed in the sense that his place will be taken in private practice largely by the hospital, the consultant and the specialist. "No doctor can sit in his private office and pretend that he knows all that he should know about the intricacies and ramifications of scientific medicine. The only place where medicine can be practiced scientifically is the hospital or medical center.

(*Continued on page* 136)

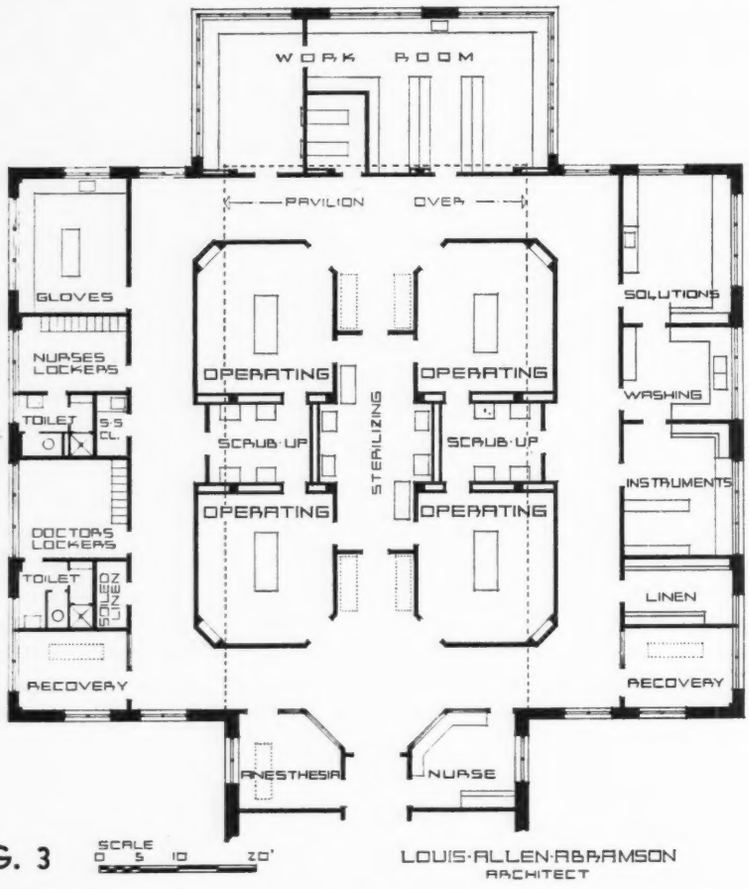



FIG. 3

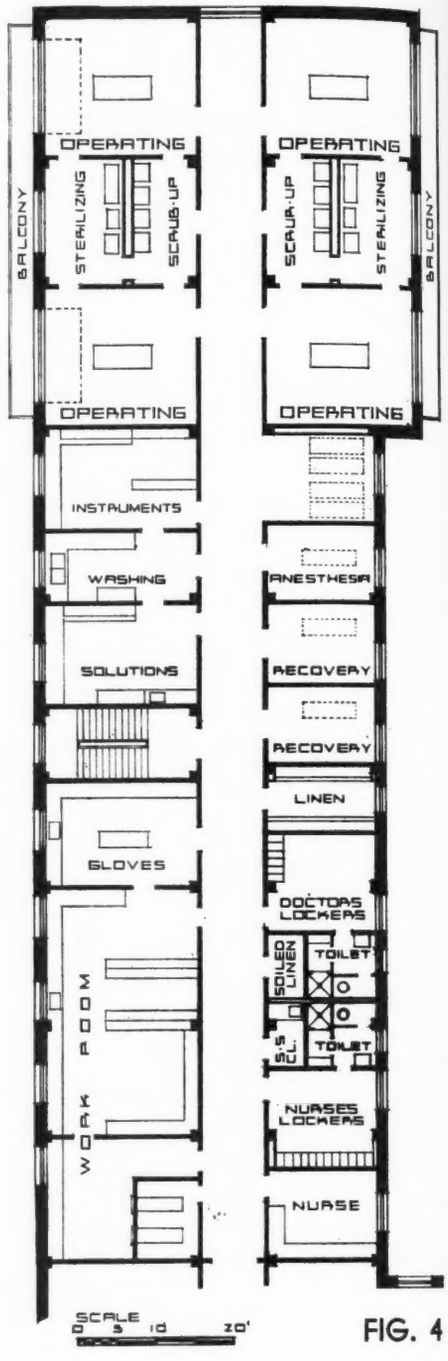



FIG. 4

**ABOVE: In Fig. 3 the operating rooms are the nucleus around which the various service rooms are grouped. The plan assumes that surgery service is housed on a lower story level, which permits the spatial limits to be dictated solely by the requirements of the work area. In this plan, too, travel is reduced to a minimum. RIGHT: In contrast, Fig. 4 shows the extended traffic lanes found in the traditional design that is based on the theory of upper story location.**

**BELOW: Diagrammatical representations of space distribution. Fig. 1 illustrates the traditional method of allocating space, whereas Fig. 2 is based upon the theory of functional relationship, wherein the professional services occupy the less desirable stories of the hospital and the upper stories are available to the patients who can benefit by the advantages of pleasant environment and comparative quiet.**

FIG. 1

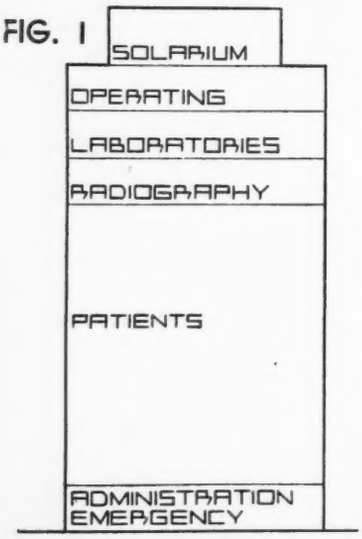
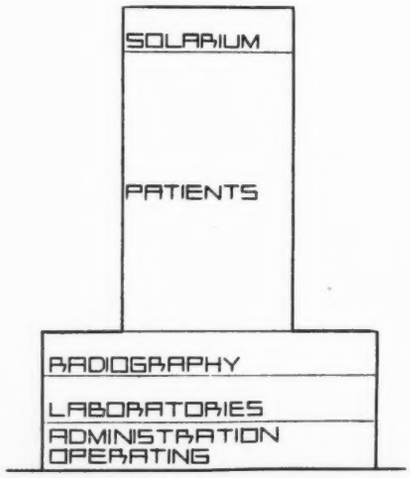



FIG. 2




**OPPOSITE PAGE: Fig. 5 shows the difference in the amount of travel required by the plans shown in Figs. 3 and 4. By multiplying the average distances between given points by the number of return trips per nurse per day, the saving in time and energy that can be effected by the plan shown in Fig. 3 can be properly estimated.**

# In Planning Hospitals Let the FUNCTION Dictate the FORM

**LOUIS ALLEN ABRAMSON**
ARCHITECT, NEW YORK CITY

A COMPARATIVE analysis of general hospital plans, even those of recent origin, reveals a marked dissimilarity in external forms and of internal arrangements of the various service subdivisions. And properly so, as specific community needs and the inclinations and preferences of the designer and his client should rightfully be expressed in terms of individual concept of service and social responsibility.

However, in perhaps 95 per cent of the plans one does become aware of an apparent similarity of purpose that has dictated the distribution of services upon the assumption that the operating and their accessory rooms must be located on an upper story.

Is this hypothesis correctly assumed? *Must* the operating pavilions occupy areas far more desirable for patient accommodations, and *must* the operating room be implemented with expansive windows, generally oriented to the north? I think not and I believe that much too frequently the architect has precipitately and erroneously accepted precedent as a conclusion of fact.

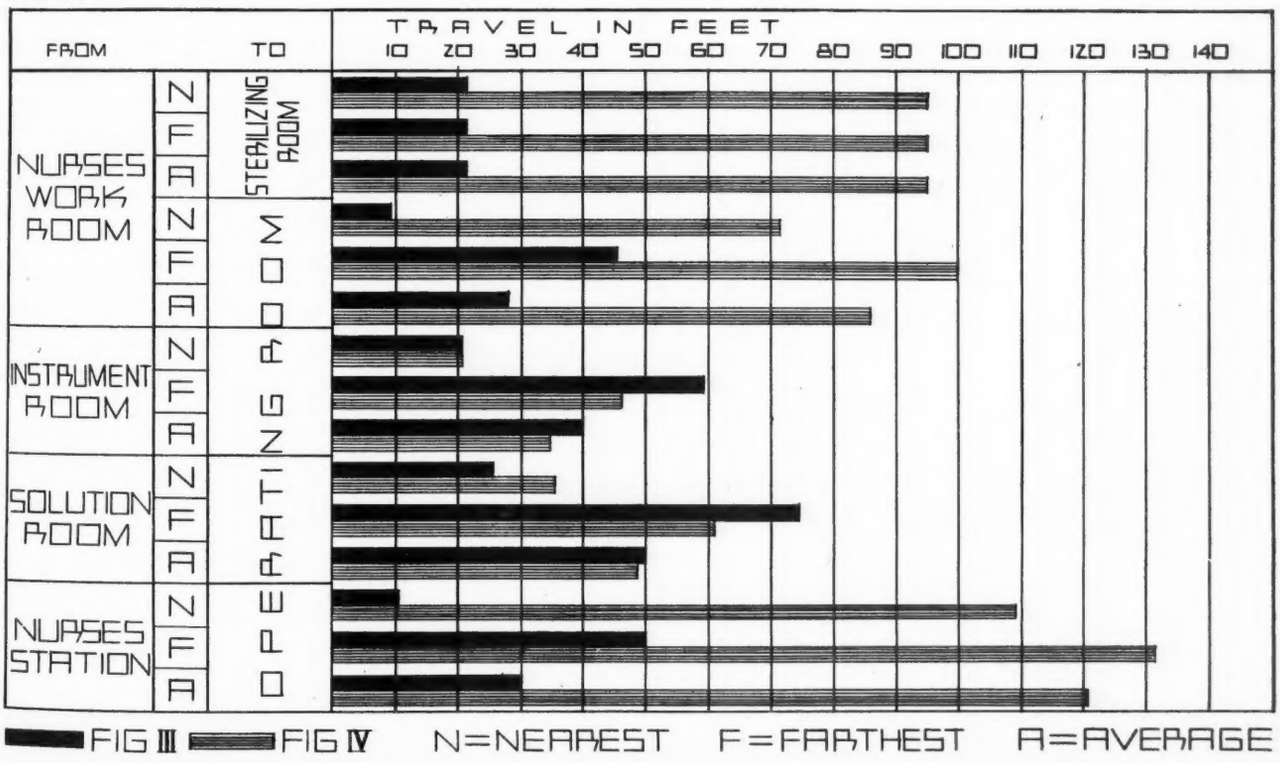
The objectives to be achieved in establishing an intelligent integration of hospital subdivisions or services are, first, a proper functional interrelationship between such services and efficient workability between rooms within each service; second, the placing of patient accommodations where the patients may best benefit by environment. But inasmuch as the preponderance of precedent favors upper floor locations for the operating rooms and related services, it may be well to pause and question whether such choice is a logical one.

As an essential prerequisite of service, and without regard to specific site requirements, the emergency or accident service must be located at or adjacent to a grade entrance. By planning the operating rooms contiguously, an immediate advantage results. One or more operating rooms may under this arrangement assume a duality of function and the emergency operating room, sterilizing, supply and other service rooms may be omitted or at least restricted. Too, this fusion of services might well result in an economy in staff personnel.

If the complete diagnostic services are relegated to a location reasonably adjacent to the operating room, the essential functional relationship is maintained, thereby releasing additional upper story areas for more desirable patient accommodations.

To lessen discomfort and post-operative shock and to avoid dislocation of nursing service, surgery patients both prior and subsequent to an operation should be exposed

FIG. 5



to a minimum of travel and traffic. It follows that if the surgical wards adjoin the operating rooms, the distance between them diminishes and the relationship becomes increasingly functional. The maintenance of the relationship is important for it has been estimated that of all the general hospital admissions in the city of New York, 60 per cent suffer surgical conditions, while 54 per cent submit to surgical operations.*

Such patients, it may be reasonably assumed, will suffer pain or acute distress for longer periods of their hospitalization than those in other services. They will seek release in natural or induced slumber and, consequently, will be less likely to be influenced by orientation, sunshine or other environmental considerations and less subject to the irritating impact of noise. Here again, by placing the surgical wards contiguous to the operating rooms, more desirable space is released for other services.

Thus has been evolved a distribution of areas based solely upon functional criteria (figs. 1 and 2) wherein the professional services absorb the less desirable stories and the acutely distressed group of patients is assigned to an intermediate location. The much preferred upper stories become available for patients of the medical, maternity and other services —patients who are responsively susceptive to psychological and physiological advantages of environment and comparative quiet.

There are additional and collateral advantages resulting from the arrangements indicated in figure 3. For if the surgery service is housed on a lower story level, the designer is no longer troubled by the frequently perplexing problem of efficiently and effectively utilizing the "excess width" required by the operating rooms when superimposed upon the patient areas. At grade, the structural barrier of exterior walls no longer hampers him and the spatial limits become expansible and flexible, to be determined solely by the physical requirement of the working area.

Accepting the fundamental conception that natural light is unneeded and granting the possibility of economic and functional advantages to operating rooms planned on a lower story level, a departure from orthodox forms suggests itself (fig. 3). Here the operating rooms become "inside" rooms as a central nucleus around which the entire periphery is utilized for a compactly integrated grouping of nurses' service rooms—spaces for which natural light and ventilation are desirable and between which the avenues of traffic should be at a minimum.

The possibilities of such a plan are suggested in essence in figure 3, while for purposes of comparison figure 4 indicates a not uncommon and basically acceptable arrangement, planned upon the dominant theory of an upper story location utilizing natural lighting. Both schemes are intended to be identical in number and floor area of corresponding rooms.

It would not be presumptuous to assume that the average reaction to figure 3 should be favorable. Even to those who are unfamiliar with operating room organization, its functional compactness and integration of service relationship must be appealing.

Apart from any other demonstrated virtues, if a plan successfully reduces travel to an irreducible minimum as does that shown in figure 3, it at least merits sincere consideration and should not be dismissed upon grounds of novelty. Conversely, if a plan such as is shown in figure 4 unnecessarily extends traffic lanes and offers no defense other than that of orthodoxy, its proponents assume an untenable position.

A graphic representation of the principal and most frequently used avenues of traffic is shown in figure 5. If the average distances between given points are multiplied by the required number of return trips per nurse per day, the possible reduction in time becomes appreciable and the probable conservation of physical energy can be appraised.

*Calculated by S. S. Goldwater, M.D., and J. J. Golub, M.D., 1941 Hospital Yearbook, upon statistics obtained from the United Hospital Fund.

# For the Protection of Plasma

**To minimize the danger of air-borne contamination in the plasma room at West Jersey Homeopathic Hospital, Camden, N. J., the windows were sealed, pipe openings were made air-tight and a dust lock was constructed on the door leading to a rather dusty hall. In addition, an ultraviolet air sterilizer was installed. The room is ventilated by an electric exhaust fan. Equipment includes a work table with a bacteriological hood that is steamed before use; a special plasma centrifuge, and two freezing units separated by a washstand.**

# *So you think you have* AUTHORITY

*Anyone can give orders but authority, such as administrators should possess, implies the ability to have those orders accepted and carried out—promptly and thoroughly*

**RAY E. BROWN**

STUDENT IN HOSPITAL ADMINISTRATION, UNIVERSITY OF CHICAGO
FORMER ADMINISTRATOR, SHELBY HOSPITAL, SHELBY, N. C.

"THE board of trustees cannot give authority—no one can give authority." That was my rather startling reply to a complaint of a fellow administrator some time ago. Fearing that he might pronounce me a Nihilist I carried the thought further. This article is concerned with the reasoning behind such a statement.

If, as administrator, I tell Mrs. Goode, the dietitian, that the silver should be polished each week and the silver is well polished each week, it is apparent that authority exists. Two things took place—an order was given and an order was accepted. The acceptance of the order was proof of the authority.

Giving of orders, then, does not compose authority. Authority is the ability to have orders accepted and performed. It is the ability to govern what is done, or is not done, and the manner and extent to which it is done. The thoroughness with which orders are carried out is of most importance.

### Power Mistaken for Authority

By now it might seem that I have confused power with ability and that authority represents the power to say what is done. Such confusion of power with authority has resulted in the failure to realize that authority must be developed in an organization. This failure has resulted in the failure of the persons in power. They have depended on their title to create authority for them when it could only give the right to originate orders and, far worse for them, the responsibility of having orders performed.

No matter how much the board of trustees might support the administrator and the administrator might, in turn, support the department heads they can only provide the right to give orders and the power of dismissal. Admittedly, these rights are essential to the creation of authority but they must be regarded only as conditions precedent to the development of authority. Which orders will be obeyed or disobeyed is decided by the person to whom the order is given and not by the person who issues it.

### Employe Makes the Decision

The discharge or, conversely, the resignation of an employe is but final proof that the power to decide as to whether authority exists rests with the individual of whom performance is demanded. At times individuals choose to give up jobs rather than perform tasks which for some reason they do not see fit to perform.

The exit interview brings out such statements as: "I just can't work for that man," or "She just doesn't know what she wants" and "They didn't tell me that I had to do that when I started working here." These remarks are meaningful and go far to explain disorganization from lack of authority within departments.

Termination of employment, however, is the rare rather than the common result. If all orders were fully performed or completely refused the problem would be simplified. The great harm comes from relative degrees of performance. The floor cleaner accepts the order to mop the floor—but look at the floor when he has finished. The nurse gives care to her patients—but what sort of care? Mrs. Goode's kitchen boy polishes the silver—but how well and how fast? These things not only give the administrator gray hair but give the hospital a name.

If acceptance and performance of orders determine authority and the decision to perform and the extent of performance can be made only by the person to whom the order is given, then good administration is dependent upon the issuance of orders that are capable of being fully accepted and performed. This fact must be recognized.

### How an Organization Functions

The purpose of any organization is to function and it is only by the performance of tasks outlined through orders that the organization does function. The manner in which tasks (orders) are performed is the measure of the hospital in action.

Assuming that the order is a good one, what are the characteristics that determine whether it will be efficiently carried out? Bearing in mind the danger of oversimplification of the complex problem of executive control, and again acknowledging the greater importance of proper policies, I list six character-

istics that are necessary before orders can be fully performed. These are the six requisites of all orders if authority is to be developed.

1. The order must be consistent with the personal interests of the person who is given the order. When Mrs. Goode returned to the kitchen to start someone to polishing silver she didn't ask the head cook to do it. Not because he couldn't polish silver but because she knew that he probably wouldn't. If he had done the work, the chances of its being done satisfactorily would have been slight and the resentment created would have materially affected future performance of his cooking duties. With this in mind she no doubt assigned the work to an employe of lower status.

Here again there could be complications. If the silver polishing required overtime work, adjustments in pay or duties might be called for. If it meant overburdening this worker in relation to the jobs of the other workers, a feeling of imposition would hurt the efficiency of all tasks that this worker was supposed to perform. Conflicts between personal interest and the job can explain many conditions of inefficiency.

2. The person to whom the order is given must be mentally and physically able to carry it out. If, by a stretch of the imagination, Mrs. Goode had delegated the silver cleaning task to the head cook and then told the dishwasher to handle the head cook's duties, a like stretch of the imagination is not needed to know the results.

No matter how much the dishwasher might have wanted to carry on the duties of the head cook there was small chance of his doing so efficiently. Many questions of job specification and employe qualification are instantly recognized. It is surprising how many of our problems arise from disregard of this point.

3. The order must be understood. This is so self-evident as to appear silly when listed. But do we always make our orders as clear as necessary and satisfy ourselves that they are understood? This is answered by the number of times employes complain that they "didn't know you meant that." And don't believe that such remarks are always alibis.

4. The order must appear to the person who receives it to be consistent with the general purpose of the organization. If Mrs. Goode's dishwasher had been ordered to polish the silver following each meal the boy would have been dumfounded. One polishing a week would appear reasonable for the needs of the hospital but three times a day wouldn't make sense. No work is done satisfactorily unless it does make sense. The number of questions employes ask each other concerning work going on in various parts of the hospital have a meaning deeper than idle curiosity—they are a part of the eternal effort of everyone to adjust himself to the work and to attempt to make the parts fit into a whole.

Several administrators have realized this fact and have issued booklets to employes in an effort to acquaint them with the general purposes of the hospital and the way each department fits into the total picture. Often when methods or policies are radically changed, administrators are forced to have employe meetings and explain new policies so that no imaginary conflicts between purpose and orders will appear.

It is the same idea of general purpose that allows the continuity of work from task to task and from day to day. Many tasks are done without orders because they need to be done according to the employe's idea of the general purpose of his job and his department.

5. The manner in which the order is given must not have a negative effect upon the performance of the order. There is a carload of psychology here. Did an employe ever tell you, "I want to be transferred; that supervisor is too busy"? Did you ever hear this one: "He let's a little authority go to his head"? Did you ever consider why employes don't get along at all in one department and then go like a house afire when transferred to another?

6. The order must place definite responsibility for its performance. Everybody's duty is nobody's duty and division of responsibility will always mean division of efficiency. If Mrs. Goode had attended to the silver polishing order by simply announcing to the kitchen force that henceforth the silver was to be polished each week she would have accomplished little more than expressing a wish—there would have been little luster added to the silver. All of us have a tendency to shirk responsibility and when there is a certain amount of exertion thrown in the tendency becomes overgrown.

Responsibility not only is important for use in placing blame but serves an equally vital purpose in giving praise. Much support can be given for the latter as being of decidedly larger consequence as an incentive to performance. Recognition often, perhaps too often in our low-paying hospital field, complements wages as a means of reward for efficient service. But whatever the relative merits of praise or blame, we do know that there is great incentive to do careful and energetic work when praise and blame can be accurately placed. Orders, like parcel post, go further if addressed to someone.

These are the characteristics necessary in orders if they are to be efficiently performed. A job is the total of orders concerning and outlining one worker's duties and the amount of authority held by the supervisor is measured only by the manner in which duties are performed. Of course, the development of authority must be preceded by the right to issue orders and the power of dismissal but to possess power is not the same as to possess authority, for as the late Justice Brandeis said, "Efficiency is present only when there is acceptance."



# Let the Patient REST

Sirs:

Two recent hospital experiences—one in a large modern institution and one in a small private hospital—impressed me keenly with the significance of the article, "Rest in the Hospital," by a "Doctor-Patient" which appeared in the May 1942 issue of The MODERN HOSPITAL. It is unfortunately too true that skilled medical and nursing care is definitely handicapped because of constant interruptions.

I am a graduate nurse and have had eight years of active hospital experience so I know that there are remedies for this situation. But until doctors and hospital administrators realize the seriousness of the problem, it is futile to seek a solution.

In the hope of arousing greater interest in the subject, however, I am offering a few suggestions that may be helpful in making "rest in the hospital" really restful.

**A NURSE-PATIENT**

THIS problem might well be placed on the agenda for discussion at future county, state and national meetings of the various hospital and nursing associations. Furthermore, I would recommend that the American Hospital Association consider the appointment of a qualified person to make a study of various types of institutions and submit his findings and ideas for possible remedies to an A.H.A. committee.

In order to reap results, this person should be admitted incognito to a two bed room for three days' observation. After this experience he would have the facts and could make practical suggestions.

A few years ago the railroads did this very thing. The Challenger, on the Union Pacific, and the Scout, on the Santa Fe, were the gratifying results from which thousands of travelers have benefited.

There are many little extras hospitals could perform with little added cost. In this county institution, admitting more than 5000 girls and boys annually, every child receives a birthday remembrance.

Large and small, voluntary and governmental hospitals, each has its own problems. Therefore, it would be helpful for hospitals to schedule staff meetings with administrators, house doctors, interns, supervising nurses, dietitians and housekeepers attending, with "Rest in a Hospital" as the subject for discussion.

During a brief stay in a two bed room in a large hospital I kept a log on which I recorded 36 entrances into the room between 6:30 a.m. and 7:30 p.m. As I was not seriously ill the interruptions did not annoy me. However, the other patient had just had an operation and needed rest. This log did not include the entrances into the room for her. One evening she was given a hypodermic at 7:20; at 7:45 she had just dropped off to sleep and was awakened by a nurse turning on the light and asking, "How much fluid have you taken?"

In this particular hospital I believe a list for daily nourishment could be placed on the daily breakfast tray and checked with the menu, saving two trips into the room. On the same list could be typed the question, "Do you wish free library service today?" This would eliminate another interruption for patients who are too ill to read.

In some instances, in private and semiprivate rooms, one nurse could distribute nourishments when taking temperatures. Instead of one nurse taking 30 temperatures and another distributing 30 nourishments, each could perform both services for 15 patients.

The housekeepers could arrange in most hospitals to have windows washed or draperies changed when rooms are vacant. Linens could be distributed each morning at bath time directly to the nurse giving morning care.

Delivery of incoming mail and flowers, twice daily, would eliminate several entrances into the room.

*All hospitals should declare definite daily rest periods similar to the plan in tuberculosis hospitals.* During this time visitors, interns, maids, dietitians, nurses' aides, librarians—everyone —would be barred from the room, except, of course, for emergency needs.

It should be helpful to give a questionnaire to each patient when he is discharged, asking if he found it difficult to get sufficient rest and soliciting his suggestions. Many of the ideas would be impractical, but from the pooled thinking should come some good suggestions.

Research could be done with gravely ill animals, giving one group expert medical care but constantly awakening and interrupting them, and giving identical treatment to another group, providing regular prolonged rest periods.

The seriousness of this problem was first brought to my attention in 1936 when my mother was gravely ill and finally passed away in a large city hospital. Many days the kindly, expert, skilled medical and nursing care was definitely defeated by the stream of traffic in and out of her room. On the day she was given her third blood transfusion a maid entered and changed the draperies and chintz chair covers just as she was about to drop off to sleep.

I am sincere in my belief that if we accept the fact that hospitals are created for the welfare of the patients, then it is of paramount importance that an effort be made to overcome this defect in hospital care.

# Proof of the PRACTICABILITY of Refrigeration Anesthesia

◀ IN THEORY

JOSEPH C. DOANE, M.D.

APPARENTLY the benumbing of sensation so that operations could be performed without pain to the patient is an ancient practice.

In 1646, Severino, an Italian, wrote a monograph on the use of freezing mixtures of snow and ice for the production of surgical anesthesia. A few years ago, in a study of the control of cell growth and reproduction in cancer, Temple Fay, Lawrence Smith and their colleagues in Philadelphia endeavored to halt the growth of malignant cells by the general refrigeration of the body.[1] In patients so treated by the use of a mechanical refrigeration apparatus, coupled to blankets so constructed that the refrigeration fluid enveloped the part, the body temperature could be much reduced and these investigators believe that malignant cell growth was inhibited.

### Local Pain Controlled

Later, Fay and others adapted the principle of the local application of cold to the control of local pain. Whether the cause of such a reduction in pain perception is some protoplasmic change in the tissue itself or whether it is a combination of this effect with a neural benumbing does not detract from the fact that local pain, such as is seen in the various types of neuritis, in pleurisy, in arthritis and even in deep-seated abdominal conditions, is relieved by these measures.

More recently, Crossman, Allen, Hurley and others have described in the current medical literature the beneficial results of employing cold in producing anesthesia of the extremities in conditions requiring amputation.[2]

Many clinicians interested in peripheral vascular disease have been inclined in the past to apply heat to a limb when its blood supply had been suddenly reduced or even when vessels were completely occluded. This practice, in the light of our present knowledge, does not now appear reasonable inasmuch as heat increases the metabolism of the part, more oxygen is required and, hence, the development of gangrene is fostered because the ordinary oxygen demands of the limb have been thus heightened.

It is said that limbs at ordinary temperature can survive for from twelve to fifteen hours if they are completely deprived of blood. If the temperature of the part is elevated or lowered, death of the tissue will be hastened or retarded. In other words, tissue at a temperature just above freezing will live for days, weeks or even months, whereas tissue at a higher temperature cannot survive so long.

The use of cold as an anesthetic in the amputation of the limbs, particularly the lower limbs, has many advantages. Operations can be performed with little or no shock to patients. There is no pre-operative or postoperative pain. Healing is in no way retarded. There are no contraindications, such as are present in some other types of anesthesia.

Let us now discuss some of the practical points to be observed in the use of cold as an anesthetic agent. Two methods can be employed.

If the hospital is fortunate enough to possess a mechanical apparatus with refrigeration blankets for the limbs, the procedure need not be cumbersome; the danger of wetting the bed or of chilling the patient's body by contact with melted ice water is thus obviated. Many hospitals do not possess such an apparatus and must resort to the use of ice. Jules Gordon has recently described a box, simple in construction, that can be employed to enclose the limb in ice.[3]

### Ice Bags Can Be Used

If neither the mechanical apparatus nor a box such as Gordon describes is available, the following technic may be employed. Ice bags are placed on the upper leg before the tourniquet is applied. This step is taken to avoid the pain incident to the application of the tourniquet. The patient's foot on the affected side is then elevated to return the blood of the leg into the general circulation.

Sometimes an Esmarch bandage is employed to compress the blood from the leg, beginning at the toe and bandaging toward the point of amputation. A half inch gum rubber tourniquet is then applied and is reenforced by a second wrapping around the leg. A rubber sheet upon which a half inch layer of cracked ice has been placed is put under the leg.

The whole leg is then covered with ice, which extends 1 or 2 inches proximal to the point at which the tourniquet has been applied. The head of the bed is then raised. The distal portion of the rubber blanket is fashioned into a funnel and a pail

[1] Fay, T.: Observations on Prolonged Human Refrigeration. New York State J. Med. **40**:1351 (Sept. 15) 1940.

[2] Crossman, L. W., Allen, F. M., Hurley, V., Ruggiero, W., Warden, C. E.: Refrigeration Anesthesia. Anesth. & Analg. **21**:241 (Sept.-Oct.) 1942.

[3] Gordon, J. D.: Box for Amputation. Am. J. Surg. **58**:453 (Dec.) 1942.

is set at the foot of the bed to receive the water resulting from the melting of the ice.

If the amputation is to take place below the knee, the patient may be propped up in a chair and the foot immersed in a pail of cracked ice. After two or three hours anesthesia should be present and the patient may be moved to the operating room.

There the leg is quickly dried, with no rubbing of the skin, and is draped with sterile towels or a surgical boot. The operation then proceeds as is customary with any other form of anesthesia. The tourniquet is not removed until all vessels have been ligated. Silk is used for sutures and ligatures. The solutions employed should be chilled and the instruments cold. The incision should be about 3 inches distal to the tourniquet.

Inasmuch as the anesthesia will last at least an hour, no great haste is necessary. After the amputation, some surgeons place the stump on a posterior molded splint, and the majority apply ice caps for a period of from forty-eight to seventy-two hours, so as to allow the temperature of the part to return slowly to that of other tissues. Since the temperature of the skin does not fall below 40°F., no sloughing of flaps from cold results. When electric refrigeration is employed, a cooled cradle is used instead of the ice caps.

This type of anesthesia is effective and often life-saving because it is based on the principle of producing anesthesia of the protoplasm instead of the nerves and depends upon the circulation of no chemical toxins in the tissues. Anesthesia by cold is particularly adapted for use in cases of patients who, although toxic and weakened by the slowly developing gangrene of diabetes or arteriosclerosis, yet require an amputation as a life-saving procedure.

# EXPERIENCE in ST. LOUIS

**MITCHELL D. JOHNSON, M.D.**
RESIDENT IN SURGERY, ST. LOUIS CITY HOSPITAL

**DURING the last six months, refrigeration anesthesia has been employed 11 times at St. Louis City Hospital. Three mid-thigh amputations and five supra-condylar amputations have been performed for either diabetic or arteriosclerotic gangrene or both. One amputation of the thumb and two sequestrectomies of the leg were done.**

**Following the amputation ice bags were placed about the stump for a period of forty-eight hours. If there was any reason to suspect infection of the stump at the time of the operation, the ice bags were left about the stump for a longer period of time. The ice bags retard the agglutination of the wound edges and permit drainage of the stump. Healing is retarded by the application of the ice bags about the stump and the sutures were not removed until the twelfth or fourteenth postoperative day. The patients seldom required sedation postoperatively and did not miss a meal. Our patients have been placed in a wheel chair either the day of operation or the following day.**

**There have been three deaths in this series. Two of them have followed supra-condylar amputations (one healed and one unhealed), and one has followed a mid-thigh amputation, unhealed at the time of death. In these few cases in which amputations of the leg were performed our mortality rate for the last six months has been 37½ per cent. The mortality rate for similar cases during the seventeen months preceding the use of refrigeration anesthesia was 55 per cent of the total 20 cases.**

**Our series is small and, hence, this must be considered a preliminary report. It is our opinion, however, that refrigeration produces a satisfactory anesthesia for operations on the extremity. This type of anesthesia has the great advantage of not producing shock in an otherwise poor operative risk.**

Exterior of limestone trimmed utility building of Reading Hospital. It has greatly increased operating efficiency and released space enough in the hospital to accommodate 50 beds.

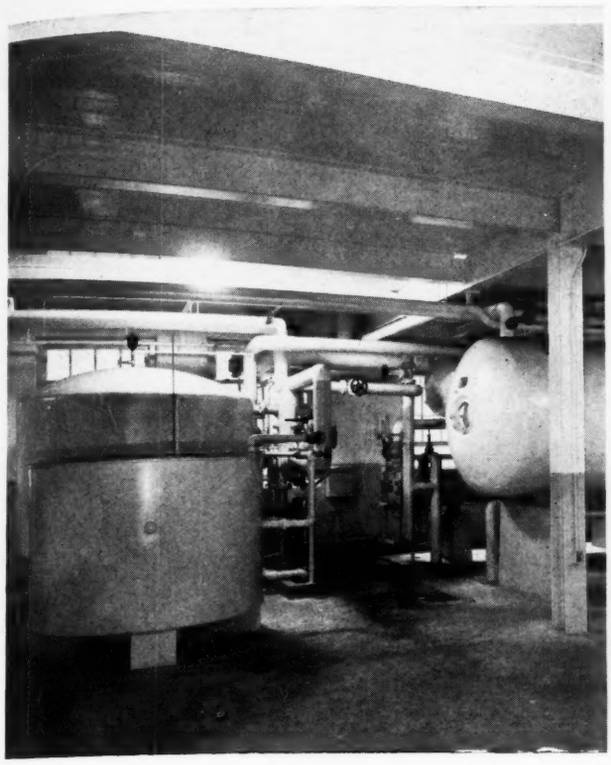
# One Utility Buildin

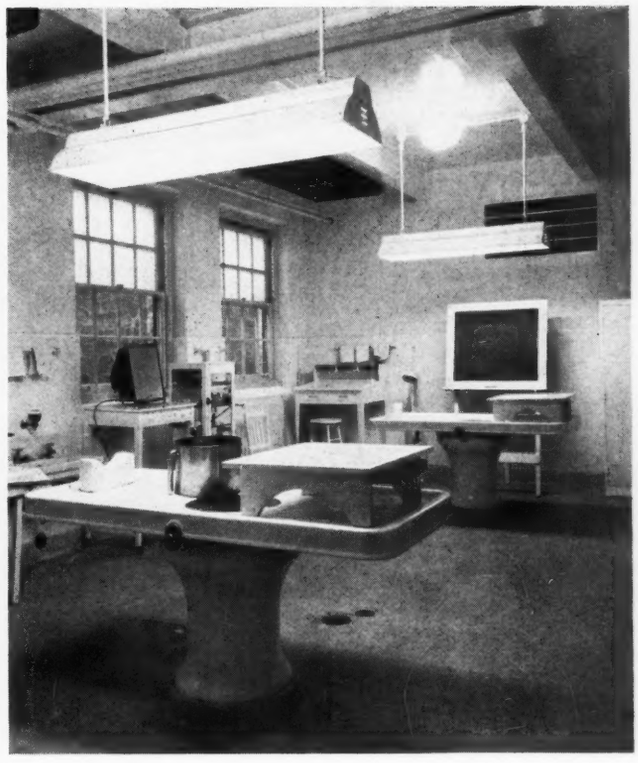
By placing the laundry on the top floor, ample light and ventilation are assured and employes work under circumstances that are conducive to good results. Adequate ventilation and good light have been attained by providing numerous windows and an abundance of overhead space. The distance from the floor to the peak of the ceiling is 35 feet. The flooring is paved with brick set on concrete and pointed with asphalt.

**E. ATWOOD JACOBS**
SUPERINTENDENT
READING HOSPITAL, READING, PA.

DURING the last ten years Reading Hospital, Reading, Pa., has experienced a constantly rising census. Following several years of peak occupancy, from 80 to 90 per cent, the board of managers concluded that plans should be studied for increasing the size of the plant. Accordingly, a careful analysis was made of space allocations which revealed that greater operating efficiency could be attained if a number of essential utilities were housed under one roof.

Early in 1940, Henry Janssen, president of the board of managers of the hospital offered to donate a maintenance building to house the repair shops, mortuary, sewing rooms and laundry. Work on the building commenced in the late summer of 1940. In the spring of 1941 the new facilities were finished and were immediately occupied. The basic plans of the maintenance building were conceived by Mr. Janssen with the hospital superintendent as consultant.





# That Equals 50 Beds

Top, left: The water softener, hot water generator and heat exchanger are located in the basement. Top, right: The necropsy room floor is constructed of terrazzo and the walls are tiled to a height of 6 feet. Examination tables, equipped with hot and cold water, are connected directly with the sewer. Above: Sewing machines and cutting tables were installed for the sewing department, which is on the first floor.

Prior to the erection of the new building, the hospital was confronted with numerous problems that could not be solved without the provision of additional space. The increase in patient occupancy necessitated expansion of the laundry. More space was required for the storage of supplies; a growing staff of employes had to be provided with proper locker and rest rooms. The location of the mortuary had never been satisfactory. The erection of the maintenance building has solved all of these problems and has released space in other buildings that will accommodate about 50 patients.

The new building is fireproof with a sustaining structure of steel and reenforced concrete. Access to the hospital is gained through a service tunnel that connects all buildings.

The building was planned to meet the needs of the hospital for many years to come. Should increased activity of the hospital tax the facilities of the departments located in this building, additional equipment can be installed without disturbing present equipment and without interrupting routine work.

# A SURVEY of SHORTAGES

ALDEN B. MILLS

MOST of the hospitals of the United States, Canada and the possessions of the United States have not as yet been seriously affected by inability to obtain essential equipment, according to a survey just completed by The MODERN HOSPITAL.

A total of 6422 questionnaires was sent to all general hospitals in the United States of 21 beds or larger, to all special hospitals in the United States of 40 beds and larger and to all hospitals, regardless of type, in Canada and United States' possessions of 100 beds or larger. In the United States this included 31 hospitals that are now under construction.

### Nearly 1500 Reply

Up to April 8, a total of 1418 replies had been received and tabulated and 75 additional replies were received too late to be tabulated. A cursory review of the 75, however, indicates that they were approximately the same as the 1418. A total of 22.1 per cent of the questionnaires sent out was returned and tabulated. Not all of those tabulated answered all of the questions, however.

The first question asked was: *"Do you have any new buildings or additions that cannot be fully used because of inability to obtain essential equipment?"* The replies were as follows:

| | *Number* | *Per Cent* |
|---|---|---|
| Yes | 63 | 4.4 |
| Don't yet know | 5 | 0.4 |
| No | 1290 | 91.0 |
| No answer | 60 | 4.2 |
| Total | 1418 | 100.0 |

Obviously, most of the reporting hospitals do not have new sections that they cannot use because of equipment shortages.

Among the 63 that are having trouble in obtaining essential equipment, the following instances are typical:

"Twelve bed ward cannot be used because of lack of nurses' call system." "Surgery incomplete." "Lack sterilizers and signal cords." "Would like to complete wing." "Awaiting equipment for one building." "Need delivery table, delivery room lights and steam table for serving room." "Had to close part of one building because of lack of fuel oil." "Remodeling of building for 48 patients held up because of delay in receiving equipment." "Need electrical equipment."

Others, along the same line, are: "Have had trouble trying to get materials for a ward building now under construction." "Need sterilizers for new wing." "Fifty bed addition, about to be occupied, needs passenger elevator." "Delay in getting faucets for water lines." "Have three unfinished floors; want to finish one but uncertain about obtaining materials and equipment."

"Nurses' home needs alteration before it can be used; we have all necessary furnishings and equipment for the home." "Trying to get isolation hospital and equipment." "Need dumb-waiter." "New 72 bed maternity wing under construction; so far government will not furnish complete equipment." "One isolation pavilion awaiting electrical and plumbing equipment." "Two floors of unfinished wing would allow 50 more beds. W.P.B. is holding up proceedings." "New addition for children's hospital needs heating equipment." "Incomplete operating, sterilization and scrub-up rooms."

Several of the 63 respondents who answered "yes" to this question apparently did so on the basis of a shortage of personnel rather than of equipment. Six such answers could be identified. Had there been a question on this subject, undoubtedly many more would have made comments like these:

"Lack necessary personnel." "One floor of 14 beds closed because of nurse shortage." "Have concentrated two wards into one to relieve staff." "Have closed one wing for lack of nurses."

### A Plea for More Help

The most eloquent plea for personnel was the following from an Ohio administrator of a chronic disease hospital:

"The help situation is worse than terrible and promises to get no better. Of the last eight people employed, six were past 60 and three could not read or write. Have more than 30 vacancies on the pay rolls, including doctors, nurses and a dietitian. Cannot get porters agile enough to wash windows. Place is getting dirty but we must neglect either the patients or the building. We are doing the best we can under the circumstances. Anything to win the war."

Question 2 asked: *"Has it been necessary for you to reduce the quality or quantity of your service to patients because of inability to obtain parts for essential equipment?"* The answers were:

| | *Number* | *Per Cent* |
|---|---|---|
| Yes | 131 | 9.2 |
| Only temporarily | 11 | 0.8 |
| Not yet | 117 | 8.3 |
| No | 1123 | 79.2 |
| No answer | 36 | 2.5 |
| Total | 1418 | 100.0 |

More than twice as many hospitals answered "yes" to this question as to question 1. Including those that have had temporary difficulties and those that anticipate difficulty

# ★*Although "business as usual" is out for the duration, the conversion of American industry to war production has not yet drastically impaired the hospital's ability to serve patients*

shortly, a total of 18 per cent, or nearly one hospital in five of those replying, finds this a serious problem. Among the items specifically mentioned are: laundry equipment, conical head for centrifuge (although ordered last August on AA-1 rating), laboratory supplies, nursery and refrigeration equipment, cable for portable x-ray machine, bedpan flusher, turbine pump, motor for stoker, repair parts for laundry, kitchen and power house, heating coils for air conditioning system in delivery rooms, electrical parts for signal lights, tubes for diathermy machine (can't get with A-1 rating), microscope, x-ray equipment (ordered last July), "B" batteries for electrocardiograph, oxygen equipment and electrical fixtures.

Under this question, also, four administrators reported a shortage of personnel.

### Maintenance Is a Problem

The third question was: *"Are your buildings being affected by your inability to obtain adequate maintenance equipment or supplies?"* The answers here showed even more trouble:

| | *Number* | *Per Cent* |
|---|---|---|
| Yes | 197 | 13.9 |
| Only minor items | 73 | 5.1 |
| Not yet | 150 | 10.6 |
| No | 943 | 66.5 |
| No answer | 55 | 3.9 |
| Total | 1418 | 100.0 |

As may be seen, a total of 19 per cent is having some difficulty and nearly 11 per cent more anticipates trouble shortly. Items mentioned are much the same as those covered under question 2.

A few additional ones are: elevator repairs, floor polishing machine, vacuum cleaner, boiler, heating equipment, plumbing equipment, valve inserts for high pressure steam line, replacements for bedpan sterilizers, gutters, emergency lighting equipment, electric water heater tank for nurses' home, stokers, ventilating fan in new cystoscopy room, wire window screens, and stoker control.

The problem of obtaining and keeping adequate help in the maintenance department seems especially acute since it was mentioned by 11 administrators as seriously interfering with maintenance of equipment.

Question 4 was in three parts. The first read: *"Do you contemplate an increased enrollment in your nursing school?"* Answers are as follows:

| | *Number* | *Per Cent* |
|---|---|---|
| Already increased | 33 | 2.3 |
| Yes | 310 | 21.9 |
| Hope to start | 3 | 0.2 |
| No | 376 | 26.5 |
| No school | 587 | 41.4 |
| No answer | 109 | 7.7 |
| Total | 1418 | 100.0 |

Of the hospitals that have schools of nursing, about half apparently have already increased or expect to increase the size of their classes.

The second part asked: *"If so, will this necessitate an addition to your nurses' home or the remodeling of existing buildings to provide living quarters?"* Only those that answered "yes" to the previous question were tabulated. The results were:

| | *Number* | *Per Cent* |
|---|---|---|
| No | 205 | 66.0 |
| Perhaps | 9 | 3.0 |
| Yes—Remodeling | 19 | 6.1 |
| Yes—Addition | 71 | 22.9 |
| Yes—New school | 6 | 2.0 |
| Total | 310 | 100.0 |

Nearly 100 construction projects to house nurses are predicted by these returns. In addition, there were four hospitals that volunteered the information that they wanted new nurses' homes or additions but do not maintain schools of nursing.

The third part of this question was an estimate of the cost of the proposed remodeling or addition to the nurses' home. Figures given ranged from $500 for a minor remodeling to $450,000 for construction of a new home. The average amount for the 69 projects for which figures were reported was $73,000. The total of all 69 projects was just over $5,000,000.

### Some New Nurses' Homes Planned

In addition, several hospitals reported that, although they are increasing their nursing enrollment, they are "getting by" through makeshift arrangements, such as the purchase of near-by residences. Some of these hospitals will build nurses' homes following the war but have not yet gone far enough to be able to estimate cost.

A further question asked hospitals *"What construction of new buildings or additions do you anticipate during 1943?"* (Of course, only essential construction will be approved by W.P.B.)

The great majority of hospitals (1241) replied that none was contemplated. One hundred seventy one hospitals in the United States and six in Canada, however, reported that some construction was planned or actually under way this year. The costs reported were $27,700,000 in the United States and $875,000 in Canada. Projects varied from small jobs costing $1000 to very large ones costing $2,500,000 or $3,000,000. A few of the nurses' homes previously discussed were also listed in answer to this question.

# *Flexible follow-up system turns*

# Debits *into* Credits

**JOHN L. BROWN**

ASSISTANT TO THE SUPERINTENDENT
SAMARITAN HOSPITAL, TROY, N. Y.

THE usual hospital credit terms specify that patients' accounts are payable weekly and in full on discharge, but in spite of the most careful follow-up while the patient is still in the hospital every institution always has some accounts that remain unpaid at the time of discharge. Some of these accounts, such as those duly authorized for payment by a responsible local welfare department, need no special individual follow-up, but every account on which payment is not definitely assured should be followed individually.

It is the purpose of this paper to describe (1) a simple and inexpensive system of records for the consistent follow-up of these accounts and (2) a standardized yet flexible procedure for the handling of individual cases.

The materials for the system of follow-up records consist of an inexpensive, light letter-sized folder for each account with the patient's name indicated on the tab, a mimeographed "collection record" form stapled on the inside of the front cover of the folder, a letter-sized set of file guides numbered from 1 to 31 for the days of the month and a set of 12 file guides.

The procedure for using these materials consists of the following simple steps:

1. Set up a folder for each new discharged account receivable.
2. File each folder alphabetically under its appropriate follow-up date. The numbered file guides for the days of the month can be set ahead from month to month, hence the necessity of only one set of daily guides. This assumes a complete turnover of the file within a period of one month, but should it be desirable to lengthen the maximum interval between follow-up dates two or more sets of numbered daily guides may be used.
3. Mark lightly in pencil the follow-up date on the patient's ledger card so that the alphabetical file of ledger cards will serve as an index to the follow-up file.
4. Remove from the follow-up file each day the accounts filed under that day, take appropriate follow-up action, record the action taken on the collection record and refile the folder on the next follow-up date, changing the penciled date on the ledger card.
5. Post all payments to both ledger card and collection record.
6. File all correspondence and papers relative to the account in the folder.
7. When the account has been paid, dismantle the folder and use it for another account.

A careful consideration of this system of records will prove that it has the following advantages:

1. A complete and concise chronological record of all transactions with respect to the particular account is produced indicating exactly what has occurred, when it occurred and who conducted each operation.
2. All of the written correspondence, papers and notes of conversations relative to the account, which may become bulky in involved legal cases, are filed neatly in one place, the individual folder, available for reference at a moment's notice.
3. The system is flexible and can be applied with equal ease to any set of credit terms that may seem desirable for a particular patient, such as one payment in full on a specified date, weekly payments, monthly payments or even irregular payments.
4. The timing of the follow-up of each individual account is practically automatic; it is necessary only to remove from the file and examine the folders filed under a particular date.
5. The individual ledger records are removed from the accounts receivable file only long enough to change the penciled follow-up date, thus minimizing the risk of losing them with consequent shortage in the monthly trial balance.

Samaritan Hospital
Troy, New York

January 15, 19 42

For the hospitalization of John Smith

from January 1, 1942 to January 15, 1942, I promise to pay to the Samaritan Hospital $ 50.00, the unpaid balance due:

in full on or before February 15, 1942

in _____ payments of _____ dollars beginning _____ 19__

Signature John Smith

Address 100 State Street

Troy, New York

Witness: J. L. Brown

**Left: A sample single payment promissory note, which is signed at the time of discharge. Opposite Page: Two of the follow-up letters sent to the patient at one month intervals when the payment has not been made.**

6. The materials for records, folders, mimeographed forms and folder tabs can be purchased for less than 3 cents per account.

7. All the work of carrying on the system, except interviewing the patients, agreeing upon credit terms and composing special letters, can be done by a person with little specialized training other than stenography.

The time involved in following patients' accounts depends upon the number of accounts, the hospital's credit policy and the frequency and regularity of payments, but it has been found from three years' experience with the method described that in a 200 bed general hospital with about 600 accounts to be followed, considerably less than half the time of a full-time office worker is required to type the correspondence and keep the records.

In the interest of efficiency it is desirable that the follow-up procedure of accounts receivable should be as uniform and simple as possible. Yet it is equally desirable that the methods used should be strictly applicable to the individual case. With these two thoughts in mind it is possible to classify for follow-up purposes most of the accounts of a general hospital in two broad categories, *i.e.* accounts that do not require individual follow-up and those that do. The former classification includes accounts that are properly authorized public welfare charges and any other account on which payment is definitely assured.

In the second group are the following eight types of accounts: (1) single payment promissory notes; (2) accounts without specific arrangement; (3) installment promissory notes; (4) industrial compensation accounts; (5) automobile accident and public liability accounts; (6) estates of deceased patients; (7) hospitalization insurance accounts on which payment is not certain, and (8) accounts with welfare orders pending.

The follow-up procedures for each of the eight types of accounts requiring individual attention have two elements in common, *i.e.* all are placed in a temporary file of discharged accounts receivable at the time the patient is discharged for examination weekly (or more frequently, if necessary) to be set up in the follow-up file as required, and all eight adapt themselves to and require a follow-up folder.

Let us now consider the specific follow-up method for each of the several types of accounts.

1. *Single Payment Promissory Notes.* The note is signed at the time the patient is discharged and the account is set up in the follow-up file at the first weekly examination of the temporary file following discharge; the ledger card is transferred to the permanent discharged accounts receivable file. Two days after the due date of the note a statement of the balance of the account is sent. One month after the due date a form letter is sent followed by other letters at one month intervals. Four months after the due date a form letter is sent advising the patient that the account is being turned over to a commercial collector and the follow-up folder is transferred from the follow-up file to the collector's file.

2. *Accounts Without Specific Arrangement.* These are handled in the same way as single payment promissory notes except that the account is set up in the follow-up file and the first statement is sent one month after discharge instead of two days after the due date of the note.

3. *Installment Promissory Notes.* The note is signed at discharge and the account is set up in the follow-up file at the first weekly examination of the temporary file following discharge. A form letter is sent whenever the patient falls behind in his payments. A different type of form letter is dispatched whenever the patient makes a small payment but one that is not sufficient to keep his payments up to date. Follow-up letters are sent when the patient has not responded to one or more form letters and when he has failed to respond to previous correspondence

THE SAMARITAN HOSPITAL
PEOPLES AND BURDETT AVENUES
TROY, NEW YORK

March 15, 1942 TELEPHONES--2109 2110 2111

Mr. John Smith
100 State Street
Troy, New York

Dear Mr. Smith:

$ 50.00

Your check for the above amount will be sincerely appreciated.

We are able to render competent hospital service to this community only through the prompt remittance of our patients.

It is easy for an item like this, outside the regular course of your affairs, to be overlooked. Now that it has again been called to your attention, however we shall look forward to receiving payment from you at once.

Very truly yours,
John L. Brown
Asst. to Superintendent

a.
JLB:PS

THE SAMARITAN HOSPITAL
PEOPLES AND BURDETT AVENUES
TROY, NEW YORK

May 15, 1942 TELEPHONES--2109 2110 2111

Mr. John Smith
100 State Street
Troy, New York

Dear Mr. Smith:

Several times before we have reminded you of your account of $ 50.00 , now past due since February 15, 1942 .

Is there any valid reason why this could not be paid and paid now? We do not believe there is.

Should it be absolutely impossible to make full payment now, then at least send as much of it as you can and make satisfactory arrangements with us for paying the balance.

Unless this account has been paid in full or definite arrangements have been made for its payment within FIFTEEN DAYS from the date of this letter we shall be forced to take whatever steps prove necessary to collect it.

Urgently yours,
John L. Brown
Asst. to Superintendent

c.
JLB:PS

and the account is badly in arrears. One month after sending the last follow-up form letter another letter is sent advising the patient that the account is being turned over to a commercial collector, and the folder is transferred to the collector's file.

4. *Industrial Compensation Accounts.* A bill is sent to the insurance carrier at discharge or every thirty days if the patient is hospitalized for more than one month. The account is allowed to remain in the temporary file for two months, then if the account is not paid after two months it is set up in the follow-up file and a compensation form letter is sent every thirty days until the account has been paid.

5. *Automobile Accident and Public Liability Accounts.* Hospitalization liens are filed at the time of discharge. The account is set up in the follow-up file at the first weekly examination of the temporary file following discharge and a legal form letter is sent one month after discharge and at appropriate intervals thereafter until the case has been settled and the account has been paid.

6. *Estates of Deceased Patients.* The account is allowed to remain in the temporary file for one month after death when a statement of the balance of the account is sent to the nearest relative. If the account has not been paid within two months after the patient's death it is set up in the follow-up file, the executor of estate is determined by inquiry at the surrogate's office and a legal form letter is sent to executor with the subject of the letter indicated as "Estate of Mr. John Patient." Legal form letters are sent to the executor until the account has been paid.

7. *Hospitalization Insurance Accounts on Which Payment Is Not Certain.* Accounts are allowed to remain in the temporary file one month after discharge. If the account has not been paid within one month after discharge it is set up in the follow-up file and a legal form letter is sent to the insurance carrier with the subject of the letter indicated as "Hospitalization Claim of Mr. John Patient." Letters are sent to the insurance carrier at appropriate intervals until the account has been paid.

8. *Accounts With Welfare Orders Pending.* The account is set up in the follow-up file at the first weekly examination of the temporary file following discharge.

Samaritan Hospital
Troy, New York

January 15, 1942

For the hospitalization of John Smith
from January 1, 1942 to January 15, 1942, I promise to pay to the Samaritan Hospital $ 50.00, the unpaid balance due:

in full on or before _____ 19__

in weekly payments five dollars beginning February 10, 1942

Signature John Smith

Address 100 State Street
Troy, New York

Witness: J. L. Brown

THE SAMARITAN HOSPITAL
PEOPLES AND BURDETT AVENUES
TROY, NEW YORK

February 12, 1942

TELEPHONES--2109 2110 2111

Mr. John Smith
100 State Street
Troy, New York

Dear Mr. Smith:

On January 15, 1942 you agreed to pay $ 5.00 each week on your account beginning on February 10, 1942.

If these payments had been made as you agreed, your account would now have been reduced to $45.00. The balance is, however, $ 50.00.

We must ask you to bring your payments up to date at once in accordance with the agreement which you signed.

Very truly yours,
John L. Brown
Asst. to Superintendent

(1)
JLB:PS

THE SAMARITAN HOSPITAL
PEOPLES AND BURDETT AVENUES
TROY, NEW YORK

February 19, 1942

TELEPHONES--2109 2110 2111

Mr. John Smith
100 State Street
Troy, New York

Dear Mr. Smith:

We acknowledge with thanks the payment of $ 5.00 made on your account on February 15, 1942 which reduces your balance to $45.00.

We remind you again, however, that according to the terms of the agreement which you signed the balance of the account should now have been further reduced to $40.00.

Since you agreed that the terms granted to you were fair and reasonable, we must insist that you bring your payments up to date at once.

Very truly yours,
John L. Brown
Asst. to Superintendent

(2-a)
JLB:FS

Top: Installment promissory note. Left: This letter is sent when the patient falls behind in payments. Right: Another type of letter that is used when a small payment is made that is not sufficient to keep the account up to date.

# It doesn't cost much to detect *TUBERCULOSIS in Mental Hospitals*

**HERMAN E. HILLEBOE, M.D.**

P. A. SURGEON-IN-CHARGE, TUBERCULOSIS CONTROL SECTION
UNITED STATES PUBLIC HEALTH SERVICE

IT IS well known that tuberculosis rates in institutions other than those for the care of the tuberculous tend to be higher than they are among the general population. While the problem of tuberculosis in such institutions may be considered primarily as epidemiologic, it is complicated by financial and other practical considerations over which the institutions have only limited control.

Patients in hospitals for the mentally ill constitute a considerable proportion of the institutional population. In the United States nearly half a million patients are hospitalized in state mental disease institutions alone. Many of these patients are tuberculous at the time of admission and many others become so during their stay. Therefore, if mental disease hospitals had at their disposal a cheap and effective means for early detection of sources of infection, a large part of their tuberculosis problem would be solved.

It was with this consideration in mind that the United States Public Health Service and the medical unit of the Minnesota Division of Social Welfare began in 1939 a cooperative experiment to determine the efficiency of the 35 mm. photofluorogram as a screening device for detection of pulmonary tuberculosis among institutional groups.

The study involved chest x-rays of 1264 patients in the Anoka State Hospital, Anoka, Minn. X-ray photographs of each patient were recorded on 35 mm. film and also on standard 14 by 17 inch film. Equipment for the 35 mm. x-ray consisted essentially of an H-shaped cast-iron standard, a rotating-anode x-ray tube and a light-tight metal box shaped like a truncated pyramid, with a type B fluorescent screen attached to one end and a precision miniature camera with a 1.5 lens to the other. This equipment is inexpensive and easy to transport, and it can be used with any transformer that will deliver a 150 milliampere current at from 60 to 90 kilovolts. Such a transformer is usually found in state institutions and can be connected and calibrated without much difficulty.

Prior to the reading of the 14 by 17 inch films, the 35 mm. films were read by transmitted light with direct magnification viewers by two physicians, neither of whom was a roentgenologist. The object of the reading of the small films was not to diagnose tuberculosis definitely, but rather to find parenchymal lesions in patients needing further study for final diagnosis. Accordingly, the 35 mm. films were classified as "abnormal," "suspect" and "negative."

Later, the 14 by 17 inch films were interpreted by a qualified roentgenologist with extensive experience in reading chest roentgenograms. Lesions were classified according to the National Tuberculosis Association standards, *i.e.* "minimal," "moderately advanced" and "far advanced." Two additional classifications were made, namely, "suspect and reserved for further diagnosis" and "no reinfection-type lesion." The reading for each small film was then checked against the reading of the corresponding large film.

Prior to the study, 66 of the 1264 patients were known to have reinfection tuberculosis. In addition to the 66 known cases, the 14 by 17 inch films revealed 180 new cases.

**Comparison of X-Ray Findings on 14 by 17 Inch and 35 mm. Chest Films by N.T.A. Diagnosis on 1264 Mental Patients at Anoka State Hospital, 1940**

| *Reading of 35 mm. Film* | *Total Cases* | *Diagnosis by 14 by 17 Inch Film (N.T.A. Classification)* *Minimal* | *Moderately Advanced* | *Far Advanced* | *Reserved or Suspect* | *No Reinfection-Type Lesion** |
|---|---|---|---|---|---|---|
| Total | 1264 | 158 | 74 | 14 | 56 | 962 |
| Abnormal or Suspicious | 301 | 140 | 71 | 14 | 45 | 31 |
| Abnormal | 182 | 79 | 60 | 14 | 18 | 11 |
| Suspicious | 119 | 61 | 11 | .... | 27 | 20 |
| Negative* | 963 | 18 | 3 | .... | 11 | 931 |
| | *Percentage Distribution of 35 mm. Readings in Each N.T.A. Group* | | | | | |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Abnormal or Suspicious | 23.8 | 88.6 | 95.9 | 100.0 | 80.3 | 3.2 |
| Abnormal | 14.4 | 50.0 | 81.0 | 100.0 | 32.1 | 1.1 |
| Suspicious | 9.4 | 38.6 | 14.9 | ..... | 48.2 | 2.1 |
| Negative* | 76.2 | 11.4 | 4.1 | ..... | 19.7 | 96.8 |
| | *Percentage Distribution of N.T.A. Readings in Each 35 mm. Group* | | | | | |
| Total | 100.0 | 12.5 | 5.9 | 1.1 | 4.4 | 76.1 |
| Abnormal or Suspicious | 100.0 | 46.5 | 23.6 | 4.7 | 15.0 | 10.2 |
| Abnormal | 100.0 | 43.3 | 33.0 | 7.7 | 10.0 | 6.0 |
| Suspicious | 100.0 | 51.3 | 9.2 | .... | 22.7 | 16.8 |
| Negative* | 100.0 | 1.9 | 0.3 | .... | 1.1 | 96.7 |

*Includes first infection-type lesions and thickened pleurae.

Abstract of "Tuberculosis Case Finding in Institutional Populations," Am. J. Pub. Health 32:5 (May) 1942.

Of the total of 246 cases, representing 19.5 per cent of the institution's population, 158 were minimal cases, 74 were moderately advanced and 14 were far advanced. In addition, 56, or 4.4 per cent of the total group, were classified as suspect and reserved for further diagnosis.

On the basis of the 35 mm. readings a total of 301 cases, or 23.8 per cent of the total group, were classified as either abnormal or suspect. Accepting as definitive the distribution of cases as revealed by the 14 by 17 inch films, the 35 mm. technic missed 18, or 11.4 per cent, of the 158 minimal cases, and 3, or 4.1 per cent, of the 74 moderately advanced cases. None of the 14 far advanced cases was missed by the 35 mm. method. In other words the small-film technic missed only three of the advanced cases—the ones representing the greatest potential danger to residents of the institution. The three undetected cases were types that were difficult to diagnose except from large plates of better than average quality.

Eleven of the 35 mm. films classified as abnormal and 20 of those classified as suspect were found to have been "over-read," inasmuch as the corresponding 14 by 17 inch films were interpreted as negative. Thus, 31, or 3.2 per cent of the 962 negative cases, were "over-read."

Detailed data on both sets of readings are given in the table on the preceding page.

It was recognized at the outset of the experiment that it is difficult to obtain uniformly good x-ray films of mentally ill patients. Because of physical deformity or lack of cooperation on the part of the patients it may be difficult or impossible to get them to assume or maintain the proper position. In many instances the use of sedatives is required, and often the upper part of the patient's body must be bound to the cassette. In evaluating the results of the experiment these considerations must be borne in mind.

In addition to the benefit to the individual patient, early diagnosis of tuberculosis among patients in institutions has many distinct advantages. Segregation of the tuberculous protects other patients and employes and results in substantial long-run economies. Moreover, inasmuch as many institutions parole their inmates, there is an obligation to the public not to release infected persons.

In states that have several institutions for the care of the mentally ill, one hospital may be set aside for the tuberculous. In this way, specialized clinical facilities and personnel need not be provided in each institution.

The results of the experiment seem to indicate that institutions for the mentally ill are well suited for application of the 35 mm. technic. If the small films are used as a screening device and all suspect cases are subjected to examination with 14 by 17 inch films, a negligible proportion of significant cases will be missed. Considering the large number of patients examined, the cost of the large films taken as a result of the "over-reading" of small films is not great. Furthermore, as the physicians who interpret the small films become more familiar with the technic the number of both over and under reading errors can be expected to decrease.

One of the strongest recommendations of the small film technic is its low cost. The cost of each processed 35 mm. film is about 1 cent, approximately 1/50 as much as a 14 by 17 inch plate. Furthermore, less personnel, time and storage space are required for the small than for the large films. From 200 to 500 mental disease patients can be examined in a day with the 35 mm. method. In institutions, such as prisons, where the subjects can cooperate fully, twice this number can be handled in a day. Hence, a traveling crew carrying the equipment described needs to spend only a few weeks in any but the largest institutions.

The office of tuberculosis control of the Public Health Service has eight 35 mm. x-ray units. At present, these units are being used chiefly for examination of large groups of workers in war industries. The units are lent to state health departments in order to demonstrate the value of the method and to encourage the states to procure similar equipment of their own. This service is part of a war-time effort to prevent the spread of tuberculosis and thus protect our precious manpower resources.

In view of the fact that patients in institutions for the mentally ill constitute a large reservoir of tuberculosis infection, it is believed that such institutions should give serious attention to this relatively new and inexpensive method for early detection of the disease.

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# *What Does the Surgeon Expect of His Hospital?*

SURELY, the surgeon should be entitled to a hospital with more than merely a well-planned operating room, able assistants, a capable laboratory. Dr. Walter Alvarez a few years ago delivered a talk on "The Pride of the Physician in His Profession." Basically, there must also be a pride of the surgeon in his hospital if he would be happy. A pride not alone in its appearance, its equipment and its bed capacity but in its moral standards, its position in the community, the capacity not of its beds but of its heart. And the heart of the hospital is the "humanitarian spirit in which the best care of the patient is always the primary consideration."

I should expect my hospital, then, to be not only a place of work but a place to serve—a place to work for the betterment of my private patients, but no less one in which I have a ward service where I am free to serve for the joy of working and the accrual of knowledge. I would wish for an opportunity to teach the interns and nurses some of the truths as I have learned them and would expect their cooperative help in return. "Tell it not in Gath," but, last, I would pray for a board of directors mindful of its duty to the community and appreciative of my labors which would uphold my arms and offer every opportunity within its power to further the art of surgery. —PAUL S. LOWENSTEIN, M.D., *St. Louis.*

# *The Case for the Clergy as MINISTERS to HEALTH*

**SEWARD HILTNER**

EXECUTIVE SECRETARY, COMMISSION ON RELIGION AND HEALTH
FEDERAL COUNCIL OF THE CHURCHES OF CHRIST IN AMERICA

CLINICAL training for the clergy was started in 1925 and since that time about 1000 ministers and theological students have had enough supervised clinical experience in hospitals and similar institutions to have a solid firsthand foundation for their work with individuals. This is indeed but a beginning, but it is a good one.

In 1925 only six of the approximately 90 accredited theological schools of the United States and Canada had courses that could legitimately be considered as falling in this field and as taking psychological and psychiatric knowledge into account. Today there are more than 50, 20 of which do a good job, and six or eight, a very good job. This field is gradually being recognized to be fully as fundamental as the study of the Bible or of church history.

A new science of pastoral theology is being born. The church started the case method and we are using it again. I feel that we are only on the threshold of this development, but it is coming.

### Clergy Has Distinctive Rôle

Without mental hygiene, psychiatry and psychosomatic medicine this modern development would have been long delayed. For the basic insights that have started us off, we owe them a deep debt. But we are not amateur psychiatrists or psychologists. We work with them; we exchange insights, but we have a distinctive rôle and a distinctive point of view as ministers of religion —and that is our strength.

I dwell on this matter of the clergy because it is the most fundamental. But many other things are happening in the church that are aspects of the movement. Let me mention some of them.

Abstract from an address to the conference on Clergy-Physician Relationship in Hospitals, Newark Academy of Medicine, 1942.

First, there is the improving and increasing of hospital chaplaincies. Even ten years ago a minister usually was compelled to look on a hospital chaplaincy as a kind of death sentence—for him, if not for the patient. Today, among the approximately 300 Protestant religious workers who give their full time to institutional ministry in this country, there is a wholly new attitude. They feel like the country doctor who has a chance to come back to the hospital for a year's fellowship or residency—it is an opportunity.

Hospitals have revaluated the position. No longer is it considered merely a symbol of the founding of the hospital at church hands or as an inexpensive means of getting financial support from the churches; hospitals now see the chaplain as performing a service for health. For as the concept of health has broadened it has become apparent that spiritual ministry may affect it as truly—or as measurably—as drugs or surgery. Incidentally, we do not consider it a detriment that a trained and competent chaplain is usually also a good public relations officer for the hospital.

We still have a long way to go. Chaplains are miserably paid as a rule and are still too often accorded only a peripheral status, dating from the days when religious sectarianism was rife. Too many hospitals do not have chaplains. Mental hospitals in particular have been slow to see the point, yet here they are needed perhaps more than anywhere else. But the trend is clear even though to some of us the performance seems slow.

Second, there is the education of the layman about religion and health. Some of conservative mind have tended to say, "That's dangerous ground because it's so often been the happy hunting ground for quackery." The basic fact is that the layman is awake to this sort of thing and if he does not get good guidance, he will get bad. At present, he is getting both but the tide is beginning to turn. Every time we doctors and ministers slip up badly a new religion and health cult is born that will have nothing to do with either profession. Part of the answer to that is better health education and better religious education for the laity, but part of it must also be better education about religion's relation to health.

### Subcommittee Indicates Trend

One of the most interesting straws in the wind is the formation recently by the general commission on evangelism of the Methodist Church of a subcommittee on emotions and mental health. An executive is even now at work who is thoroughly conversant with the field, who has had clinical training and wide experience and who will most certainly carry on a constructive program for the layman.

The commission on religion and health of the Federal Council is also an official church agency. We have a relationship to all these fields I have mentioned and try to keep in touch with them in every aspect we can. Sometimes we feel like jacks-of-all-trades but not when we can take time out and look around at the changes that have taken place in the whole field since the commission was formed five years ago.

Third, and most important for us here, there is the relationship between physicians and clergymen. From what I have said about the clergy it is obvious that there are abroad a new spirit and a new knowledge about our ministry to individuals. It is, therefore, the most natural thing in the world for ministers to be concerned with new ways of cooperating with physicians, not only in a general way by clapping

each other on the shoulder and agreeing about each other's views on politics or razor blades but in connection with the specific people we both meet daily in stress and suffering who need the healing hand of the spirit as well as the healing hand of the body.

Last spring and summer the American Protestant Hospital Association, in collaboration with the commission on religion and health, made a study of relations between doctors and ministers in eight selected Protestant hospitals. One of the most striking findings emerging from that survey was the inferiority complex that many ministers, even when well trained and competent, had about consulting with doctors concerning individual patients or parishioners.

### Most Doctors Cooperative

The odd thing was that about 85 per cent of the doctors who participated anonymously in the study reported that they welcomed consultation with the clergy. There was a minority still back in the eighteenth century so far as their understanding of what the modern minister can do was concerned, but it was less than 20 per cent. Now it is hardly to be expected that the whole 85 per cent would welcome the clergy with equal understanding and open-heartedness but the conclusion was inescapable that there is more understanding potentially in existence than is actually in practice.

On the other hand, and I risk saying this because we want to reach new levels of understanding and not just stand pat on ground already achieved, most of the doctors in the study had little information about what the ministers did in particular. That is, they tended to feel that a clergyman who was a good man would do good work because he was a nice fellow. This is an indispensable precondition as we would be the first to admit. But what if our ministerial standards of medical ability should be wholly on the basis of whether the doctor was a good fellow? That is, the doctors did not yet realize that we have made our spiritual ministry to individuals an object of study in a sense similar to their medical ministry. The fact that it has not crystallized into a system yet is hopeful for its future development. But if the point is increasingly recognized by the doctors, we shall get ahead with our program faster.

Improved and deepened understandings between clergymen and physicians are certainly on the way and they form the indispensable substructure for a constructive religion and health movement. It is on the hospital ward, in the physician's office and at the church that we shall see the movement in its real operation.

What is the war doing to this movement? And what is the movement doing in the war?

In England the growing interest in this field was just reaching a state of organization in the Committee on Cooperation of Doctors and Clergy, under the leadership of the present Archbishop of Canterbury and Lord Horder, when the war began. In Scotland a similar movement was under way but had not yet reached the stage of organization. Both movements were arrested so far as organization went, but it becomes clear that progress of the idea has continued, indeed has been accentuated, during the war. A recent report, for example, stated emphatically that theological education after the war would have to make this field a serious and fundamental aspect of its curriculum.

### War Has Stimulated Progress

In this country the progress has been even more striking. One of the reasons for this is the tremendous development in the chaplaincy service to the armed forces. Competent chaplains estimate that as much as 90 per cent of their effective service is ministry to individuals, and they have eagerly sought light on how to do this. Through the general commission on Army and Navy chaplains, our commission on religion and health has been conducting seminars for the chaplains at their military posts on the whole matter of pastoral counseling and ministry to the sick. To our gratification, these seminars have usually included meetings of the doctors and the clergy to consider together ways of improving cooperation between the two groups on the problems of individuals.

The war has hit hospital personnel hard, and it will strike still harder. So far it looks as though this would mean not a decrease in chaplaincy service but an increase. This is not because chaplains take over medical or social work functions, but because the pressure that doctors, nurses and social workers are under prevents them from treating "the patient as a person" as much as they would like to do. Hence, the chaplain's service becomes even more fundamental.

For the doctors, there is evidence that they increasingly welcome any intelligent help they can get and they are seeing that in the clergy is a great resource they have not always recognized at its full value. All this means that in war time we have an increased obligation and that awareness of this is pushing our movement ahead at fundamental points, even though some of the frills are not receiving as much attention as they might in peace time.

### Patience Is Still Needed

Doctors sometimes tell me of clergymen who have done most unwise things with their patients and ask how they can cooperate with the clergy when this happens. I have to ask for patience, for there *are* such clergymen and even the best make mistakes at times. And ministers sometimes say, "How can I cooperate with these godless doctors who ridicule religion?" And I must answer that there *are* such but to give us time and look now for the others.

For the clergy and for the doctors, I believe, this suggests how important it is for our cooperation to be on a professional as well as a personal level. If a doctor with whom I am cooperating on a particular case believes that both my patient and I are a little wacky to hold some of the convictions we do, let him think so. I should much rather have his full and wholehearted cooperation with integrity of conviction that differs from mine than a half-hearted or prudential turning to a personal religion in which he does not sincerely believe.

So it is, I believe, with the doctor. If I am not mistaken, he would rather collaborate with a clergyman who has different convictions provided there are free interchange of opinion, open-handed cooperation and full understanding where the health of the patient is concerned than with one with a groveling kind of obeisance before the mighty man of medicine. We need *professional* cooperation.

# An Administrator Thinks Out Loud

**E. M. BLUESTONE, M.D.**
DIRECTOR, MONTEFIORE HOSPITAL, NEW YORK CITY

¶ The process of differentiation whereby communicable and mental disease patients and even obstetrical patients are separated out and segregated is easily defended on social grounds, but the desire for specialization based on duration of disease, whereby the chronic disease groups (loosely termed chronic, incurable and aged) are similarly isolated and often forgotten, can have no defense that has a humanitarian basis.

¶ Unlike the worker in the exact sciences, the hospital administrator cannot hope to be governed completely in his decisions by a repetition of similar cases occurring in series.

¶ The right of a dissatisfied patient or employe to explanations when his comfort and well-being are involved is inalienable.

¶ Medication for a given patient may or may not prove to be remedial. A surgical operation may or may not prove to be successful, but medical social service, without exception, produces beneficial results.

¶ Paying a good worker his wages in money is not enough.

¶ To speak of "a direct profit to the hospital from private patients" being "morally" wrong is to make the institution appear anthropomorphic — as if someone other than the sick poor were benefiting by such "profits."

¶ The use of the term "cured" should be limited to the follow-up clinic and removed from the terminology of the ward statistician.

¶ It takes a toothache to establish a healthy medical attitude toward dental practitioners.

¶ If the dentist leans heavily toward the curative side and is more successful in this respect per cubic millimeter than the medical practitioner working over a larger area, this in itself should bring greater recognition for him in the hospital.

¶ To turn away from an employe who is in need at a crucial time, unless he pays his hospital employer for interest in his welfare, is to invite hardships in labor turnover, service and loyalty.

¶ The results of errors in treatment, made in omission or in commission, are serious out of all proportion to their causes.

¶ Our adversaries should be challenged to recommend constructive substitute methods of equal quality to finance charitable institutions when the balance between income and expenditure is disturbed by them in any way.

¶ The hospital internship for graduating students of medicine is, in effect, a multiple apprenticeship. The educational program for these young physicians should, therefore, be prepared accordingly.

¶ The ideal clinician, like the ideal employe generally, is the one who never puts you in a position where you will have to say "no" to him.

¶ There is no substitute for maturity in trusteeship.

¶ Every diploma, especially a medical diploma, is subject to an unwritten statute of limitations. This is part of the aging process. Follow-up of patients depends on follow-up of medical education.

¶ The only specialty in the hospital where psychotherapy is of no use is in the dental department.

¶ If the physician is a biologist he is also a social worker.

¶ Many hospitals are held together by the cohesive power of mutual aid more than by the spirit of efficiency that characterizes the modern organization of industrial establishments.

¶ We have found from experience at the council table that where there is good will, there is a way.

¶ Nowadays doctors give the sulfa drugs first and ask questions afterward—on the theory that it may not be necessary to bother asking questions at all. Shades of Osler!

¶ The physician who is able to take full advantage of time, money and energy and make the most productive use of them is the best of all hospital assets.

¶ Among other things the apprentice in hospital administration must be taught how to acknowledge philanthropic help gracefully.

¶ An excellent pedagogic method in the training of hospital administrators is a periodic review of the inactive filing cabinet for a discussion of the problems of a previous day and their solution in the light of recent changes.

¶ Trends, movements and tendencies in social work must be watched carefully by the hospital worker since there is no way in which the intimate connection between medicine and the social sciences can be broken.

¶ Paying a visit to the medical staff room should do the hospital administrator good from time to time since the gossip of that location has an important though curious influence on the course of hospital events.

¶ The only excuse for favoring one department in the hospital over another is the presence of special talent in that department prepared to exploit original ideas that are deserving of encouragement and that have a fair prospect of results. Mere favoritism toward one clinical department or the riding of a philanthropic hobby is out of place in a well-organized medical establishment.

¶ Giving the chief of the dental department a place on the medical board of the hospital costs no money and may, indeed, save some.

# *When the patient has a* COMMUNICABLE DISEASE

THE majority of small hospitals in the United States do not knowingly accept cases of communicable disease, according to a survey of 20 of them reporting for this month's Small Hospital Forum.

Only four of the 20 stated that they accept patients with a diagnosis of communicable disease. These four hospitals are as typical in size of the smaller hospitals as are the 16 that do not accept such patients. The four have 28, 40, 44 and 80 beds, respectively.

Of the 16 hospitals that do not accept such patients, one has fewer than 25 beds, three have from 25 to 49 beds; seven have from 50 to 74 beds, and five have 75 or more beds.

Two hospitals accepting such patients qualified their replies by stating "if the patient's condition requires hospitalization" and "if special nurses can be obtained."

### No Adequate Provision for Care

Fourteen of the hospitals that refuse communicable disease patients stated that it was because of lack of adequate provisions for their care. One reported that the demand for hospital facilities in its community was so great that it could not accept persons with communicable diseases. Another hospital asserted that the shortage of nurses forced it to decline such patients because in small hospitals they require more than average nursing care.

Although the difficulties of providing care for communicable disease cases in small hospitals are well known, the liberal attitude on this subject is expressed by Mary Malone, superintendent of the 40 bed Henderson Memorial Hospital, Henderson, Tex. "We feel that patients with communicable diseases should be cared for with communicable disease precautions and isolation. They are sick, too."

The hospitals were asked "If you do not accept patients with communicable diseases, what provision is made in your community for their care?" Four replied frankly that there was no provision and six more said that such patients had to be cared for at home with a special nurse. In six instances there is some other hospital to which they can be sent.

One hospital stated that if it is absolutely necessary to hospitalize such cases, it will break its ordinary rule and put them in private rooms, with baths, under medical supervision. Three hospitals failed to answer this question. Four of the hospitals that did reply gave two different answers.

The hospitals that accept such patients were asked to describe the provisions made for their care. W. H. Hunt of the 80 bed Maple Avenue Hospital, Dubois, Pa., stated that the patients "must have private nurses for the entire stay or else some member of the family who can carry on with a minimum of supervision must nurse them. We have an isolation unit that is complete with a separate outside entrance."

The 28 bed St. John's Hospital of Jackson, Wyo., provides special nurses and the patient is completely isolated in a private room with bath, according to Josephine C. Brown, assistant superintendent.

Mary Malone of Henderson Memorial Hospital states that their precautions are: "No visitors. Nurse wears cap, gown and mask. Hands are disinfected with saponated solution of cresol (lysol) and mercuric cyanide." The other hospital that accepts such patients, Burrell Memorial Hospital, Roanoke, Va., (44 beds) did not answer this question.

The hospitals were asked what they do when a patient develops a communicable disease after admission to the hospital. The four hospitals that regularly accept such patients merely apply their usual technic. Of the 16 other institutions, four send the patient home or to another hospital while the others isolate him in a private room providing whatever care they can.

One of these hospitals isolates "until a transfer can be effected." Another states that it dismisses the patient as soon as possible. One hospital points out that it is a great hardship to keep such patients but that it does so.

Concerning hospital employes who contract communicable diseases, the four hospitals that accept such cases treat employes the same as patients. One institution mentions that "if we are responsible for the infection, we pay for the special nurses needed."

Of the other hospitals three send the patient home or to another hospital and one of these pays the hospital bill. Four merely replied that they had never had occasion to face this problem and had no plan. Two others said the question had never arisen but that they would isolate the employe in the hospital. Five reported that they isolate the patient in the hospital. One hospital distinguishes between nurses and other employes, keeping the former in the hospital but sending the latter home.

### Few Tests Given Employes

The final question asked whether the hospital "gives any of the following tests to employes before employment or at some other time: Mantoux, Widal, Wassermann, Dick and Schick. Twelve of the hospitals give a Wassermann test to employes, although they did not specify whether this is given to all employes or how frequently. Only a few institutions give any of the other tests. Three give Mantoux tests for tuberculosis, four test Widal reactions for typhoid fever, one makes the Dick test for susceptibility to scarlet fever and one performs Schick tests for immunity to diphtheria.

In addition, one hospital reported that it gives employes and all attend-

ants a general physical examination. Others may also do this but did not report it. One other hospital stated that it made these tests "if indicated."

Sister M. Joanna, R.N., St. Catherine's Hospital, Garden City, Kan., (65 beds) stated that "we have not performed any of the above tests. The employes are from families well known to us, at least those that are employed for any length of time. Since the war, employes do not stay long enough to do any tests—a few weeks and they are off for different jobs."

Mrs. Vera Brown, R.N., of Flandreau Municipal Hospital, Flandreau, S. D., (18 beds) probably expresses the opinion of many other administrators of small hospitals. "No tests are given," she said. "Nurses have all had the tests and as for employes, I have to take what I get and be thankful. After doing the cooking myself for a week, I was glad to hire a cook with ulcers."

Sister Rose of the 75 bed St. Andrew's Hospital, Bottineau, N. D., makes her comment on tests for employes decidedly succinct: "We should, but we do not."

### This Month's Correspondents

The hospital administrators that provided information for this symposium (in addition to those who have already been mentioned) are: Bessie M. Roy, Newton Memorial Hospital, Newton, N. J., (50 beds); Clara B. Pound, Ingalls Memorial Hospital, Harvey, Ill., (120 beds); Sister M. Theodora, Mercy Hospital, Cadillac, Mich., (50 beds); Dr. E. Stanley Grannum, Good Samaritan-Waverly Hospital, Columbia, S. C., (53 beds); Maurice Tatton, Price City Hospital, Price, Utah, (56 beds); Anna Lint, The Miners Hospital, Frostburg, Md., (45 beds); Dr. G. D. Waller, Claremore Indian Hospital, Claremore, Okla., (100 beds); Julia Andersen, Grand Island Lutheran Hospital, Grand Island, Neb., (35 beds); Sister Mary Cecilia, Dermott Municipal Hospital, Dermott, Ark., (30 beds); Alice L. Bennett, Webber Hospital, Biddeford, Me., (60 beds); Donna E. Watts, Kennedy Deaconess Hospital, Havre, Mont., (60 beds); Mrs. F. L. Sanborn, Bristol Hospital, Bristol, Conn., (100 beds), and Sister M. Sebastian, Providence Hospital, Sandusky, Ohio, (125 beds).

# Albany Hospital Presents *"A. MOVIE"* Promoter of Blood Banks

**EVERETT W. JONES and F. C. VANDENBURGH**

BORN at the Albany Hospital, Albany, N. Y.,—an idea, "A. Movie"! What a handicap to start a life under—no parents and, of all things, colored, with no funds to pay expenses. E. W. Jones, director-on-leave of the hospital, took a great interest in the young idea and did not want him to languish for want of nourishment. He called in two people who he thought should be interested in adopting the feeble youngster—F. M. Nielson of Educational Film Service, Nassau, N. Y., and F. C. VanDenburgh, director of the hospital service division, E. H. Foster and Company, Inc., Cohoes, N. Y.

Mr. Nielson was to administer the proper nourishment and Mr. VanDenburgh was to direct the care. They adopted little A. Movie, christening him "Building and Operating Blood and Plasma Banks." They, with Mr. Jones, went into consultation with the personnel of Albany Hospital and of Crouse-Irving, Memorial and University hospitals of Syracuse, N. Y., to get the proper shots to give the infant idea. These hospitals all worked together to formulate the prescribed scenario of treatment.

The treatment was under the direct supervision of Dr. John B. Alsever, director of the Transfusion Service Center, University Hospital, Syracuse, and now technical consultant on blood and plasma banks to the Office of Civilian Defense, Washington, D. C. The good doctor gave to the young idea the proper technical skill and care. To him and to Dr. F. A. D. Alexander, chief of anesthesia, gas therapy and blood bank service, Albany Hospital, goes all the credit for keeping him alive and growing.

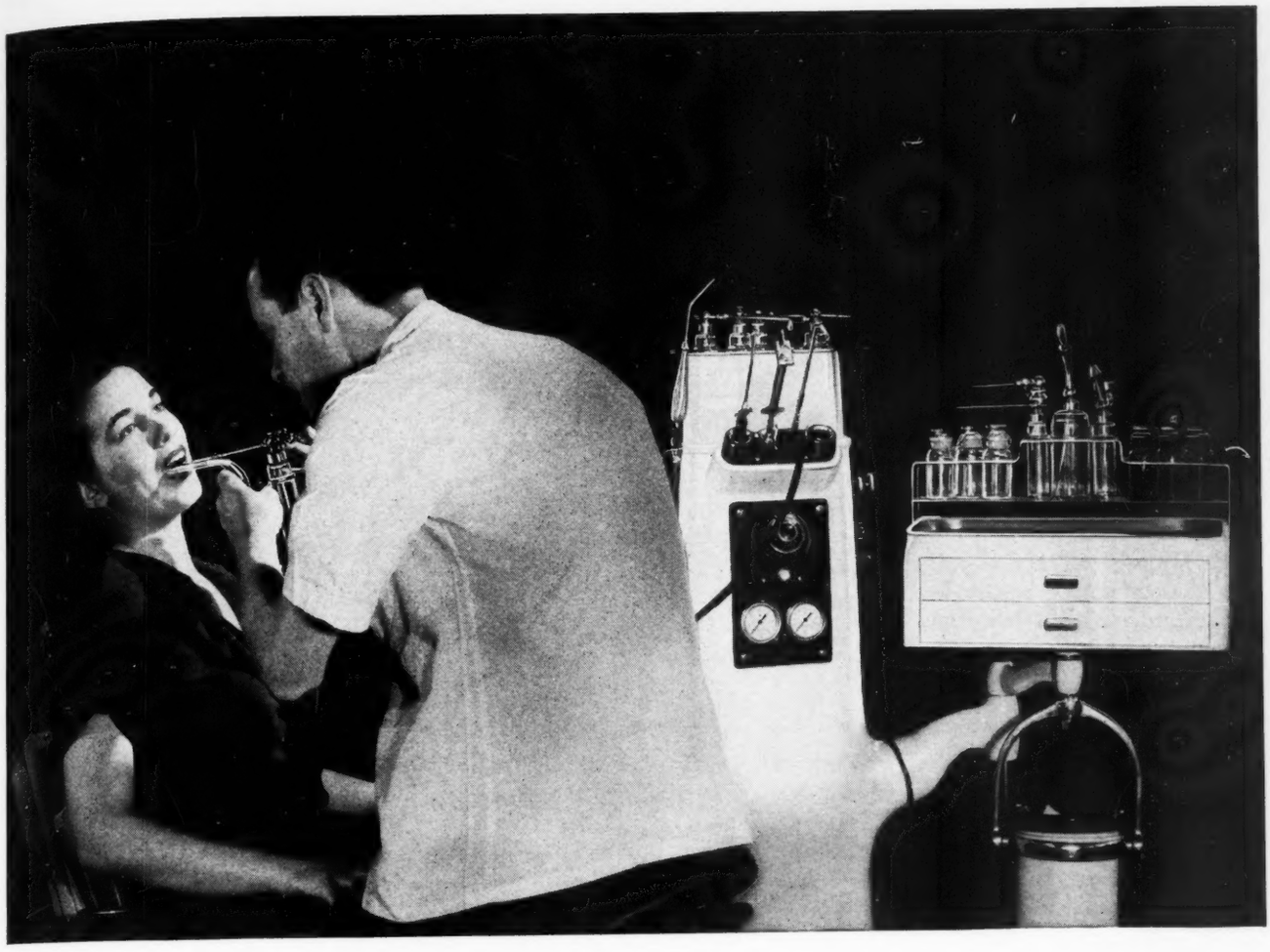
He lived and grew lusty, as forty-three 100 foot color shots were taken by the foster parents at all the hospitals listed. These shots show the state police working with the hospital in handling an emergency resulting from a traffic accident; a blood transfusion to an accident victim in the emergency room; a typical donation to a blood bank; typical centrifugation and aspiration of blood; transfusion in the operating room; transfusion in a private room; plasma transfusion to a poliomyelitis victim in an iron lung, and a plasma transfusion to a burn patient in the emergency room.

Today, "A. Movie" is a full-sized 1600 foot film capable of doing his job well, going from hospital to hospital working to stimulate interest in building and operating blood and plasma banks. He is an independent fellow whose sole purpose in life is to help get a blood bank in every hospital. Any hospital that wants to use this husky fellow for its blood bank should write for information to Albany Hospital.

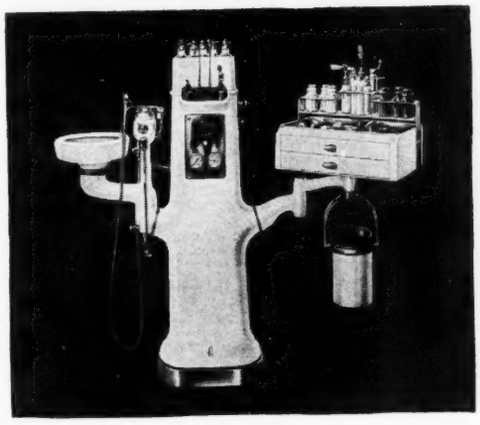
### "A. Movie" Can Help You

What can "A. Movie" do for you? He can get you a blood bank if you don't have one. This can be done by interesting your community in the value of a blood bank. This movie will also aid in obtaining blood donors. If you already have a bank, the film will help you win the complete cooperation necessary to maintain and enlarge it. Of most importance, the use of "A Movie: Building and Operating Blood and Plasma Banks" will do a fine job of improving public relations in your community.

A souvenir booklet illustrated with pictures taken from the movie is an important part of the program and should be given to all members of the audience. The combination of the movie and the booklet has produced hundreds of favorable comments from our audiences.



# Welcome Help For Hospitals



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# Why a Women's Board?

A. EPSTEIN
MEMBER OF THE BOARD
MOUNT SINAI HOSPITAL, CHICAGO

IN JANUARY 1941, a women's board was organized for Mount Sinai Hospital, Chicago. Present on this occasion were a number of guests who had previously exhibited interest in the hospital and who were considered as candidates for membership. In addition, each of the women's auxiliaries sent a representative.

The primary reason for organizing a women's board was to coordinate the activities of various women's auxiliaries and to develop such other activities and volunteer work at the hospital as could not properly be taken care of by the board of directors.

It is customary for men directors to attend such meetings as they can to discuss hospital affairs, vote "yes" or "no" on subjects brought to their attention by the superintendent and then to forget about the hospital until the next meeting. This, of course, is easily explained by the fact that they are generally business men who have not much time to devote to hospital activities beyond occasional attendance at meetings.

### Relief of Distress Is Women's Work

Women, on the other hand, are likely to have more leisure time and are in a position to devote one or two days weekly to hospital work. By nature, too, women are better adapted to work that requires sympathy, kindness and the alleviation of distress.

In these days of war emergency, lack of manpower and disorganization of all facilities, more than at any other time, women are able to fill in the gap and to furnish service when professional personnel is not available or is limited.

The field of activities for the women's board is highly diversified. The women can and do do commendable work as volunteer assistants in the clinics where, under the supervision of trained social service workers, they handle routine clerical work involving admissions, information and record keeping and even act as assistants to the doctors and nurses in charge. This work is done under the supervision of the women's board and volunteer workers are assigned to their tasks, each having certain days and hours on duty.

The same is more or less true throughout the hospital where, under the jurisdiction of the women's board, volunteers have been assigned to each floor to act as aides to nurses and doctors in purely routine work that does not involve skilled training. They take charge of information desks, telephone calls and distribution of trays during the meal hours.

Those who have received sufficient technical training prescribed by courses established by the Red Cross work as Gray Ladies and are able to perform duties as nurses' aides where fundamental knowledge in handling a patient is required and where they can be done under proper supervision without reducing the standard of efficiency.

It devolved upon the women's board of Mount Sinai Hospital to form and organize sewing and surgical dressing groups throughout the city and these groups are now busy preparing bandages, dressings, clothes bags, surgical sheets, laboratory sheets and many other articles required for the comfort of the patient. This work is being done by many Temple Sisterhoods, clubs and individuals at home. This work not only gives financial assistance to the hospital but also relieves nurses and other members of the staff.

There is a special appeal to women to make the task of nurses lighter and more enjoyable through recreational and social activities. At Mount Sinai Hospital the nursing committee of the women's board furnishes a teacher and music for the nurses' choral group; arranges parties for service men; furnishes volunteer transportation for student nurses for graduation exercises and other occasions, and keeps careful supervision over the nurses' headquarters, improving as much as possible their housing facilities and making their surroundings more homelike.

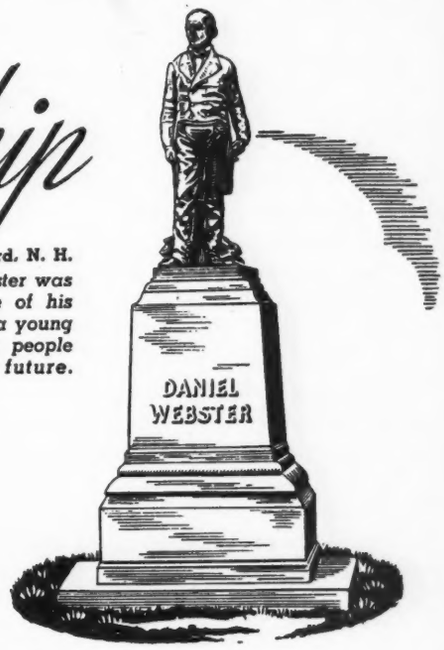
### Women as Public Relations Agents

Members of the women's board take it upon themselves to act as public relations agents, bringing the hospital and community closer together by forming sewing groups and organizing volunteer service and by conducting organized tours of the hospital, particularly on National Hospital Day. It is likewise within the province of such a board to furnish recreational and cultural opportunities for convalescent patients, such as occupational therapy, making surgical dressings and sewing; these tasks often brighten the day of the ambulant patient.

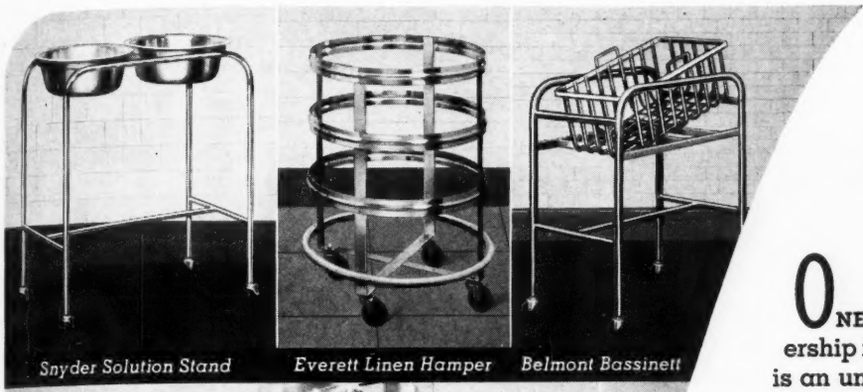
The women's board, in fact, keeps a watchful eye over hospital activities and fills in wherever help is needed. At some institutions the board provides coffee and confectionery shops, gift shops and soda fountains, in which most of the articles placed on sale are donated and the women furnish daily volunteer sales service. The same is true in handling the library—the women assume responsibility for procuring books and distributing them daily to patients.

Women could not be in contact with the clinic and dispensary for long without observing the distress of some of the patients who are unable to pay for special treatments or dietary requirements. Under the direction of the women's board, committees provide a camp fund for convalescent children, insulin for diabetics, glasses for those who are un-

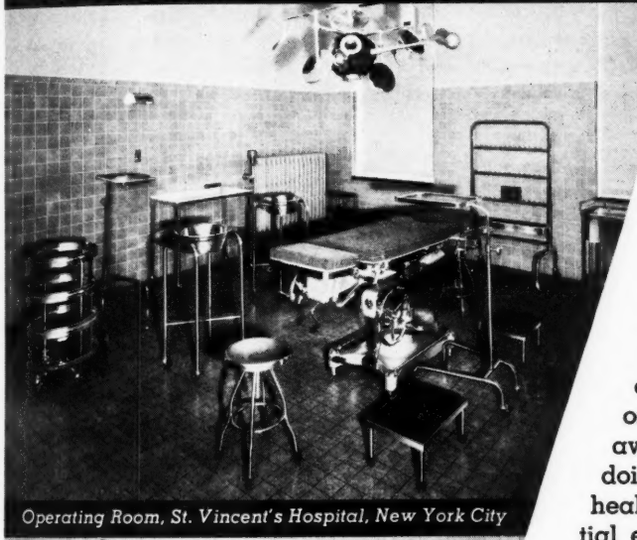
# Symbols of Leadership



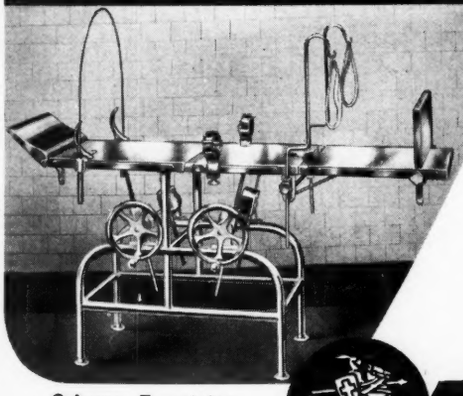

**5. Statue of DANIEL WEBSTER in Concord, N. H.** *Famous for his oratorical ability, Webster was an outstanding leader in the service of his nation. During the formative years of a young Republic, his eloquance inspired the people to love of country and faith in its future.*



*Snyder Solution Stand* *Everett Linen Hamper* *Belmont Bassinett*



*Operating Room, St. Vincent's Hospital, New York City*



*Osborne Examining and Operating Table*

ONE of the fundamental elements of leadership in industry as well as in government, is an unshakable belief in the destiny of a nation. It is this belief in essential progress which inspired "CONQUEROR" to pioneer in stainless steel hospital equipment. It is this conviction, backed by years of experience and ample manufacturing and technical resources, which will maintain "CONQUEROR" leadership in the design and construction of fine hospital equipment.

Hospital administrators everywhere are faced with wartime problems of maintenance and supply. Our production at present is devoted mainly to Government orders. But responsible authorities are well aware of the important job hospitals are doing in helping to maintain this country's health and morale. Certain types of essential equipment are expected to be made more readily available through suitable priorities. Perhaps we can be of assistance in clarifying some of the numerous questions relating to the procurement of the equipment we manufacture. Write us.

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EST. 1889

**CONQUEROR** LEADS THE WAY

*Equipment for Hospitals in a New World*

able to pay for them and many other relief measures more or less outside the jurisdiction of the hospital proper.

While it is not a primary duty of the women's board to raise funds, through their representative on the men's board they learn of the various needs of the hospital that cannot be taken care of by ordinary budgetary appropriations and often are able to go into the community, arouse interest in the particular need of the hospital and obtain financial help from philanthropically inclined persons.

At Mount Sinai the fact that representatives of all auxiliaries are on the women's board and that such representatives are able to carry the message of the hospital to the many individuals comprising their particular groups puts the hospital's contact with the community on a broad basis.

It is a prerequisite for a smoothly functioning hospital to have, in addition to its physical facilities and an able medical staff, an intelligent and cooperative board of directors, as well as an active women's board that devotes sufficient time to the affairs of the hospital.

# WOMEN'S SERVICE GROUPS

## Ready for Anything

If an emergency or disaster should occur in Battle Creek, Mich., the women's volunteer groups are trained to play a minor but important rôle at Community Hospital.

The nurses' aides, of course, will be useful, and simple tasks will be assigned to women's auxiliary workers who have completed an augmented home nursing course. The regular Red Cross home nursing course was extended so that the instructor could give added facts on methods and technics used in the hospital.

Then there are the 50 or more women who belong to the receptionists' group. They serve half a day or more a week at the hospital, greeting and directing visitors, arranging flowers and delivering plants, taking the mail around and assisting in receiving emergency cases.

These women now know who all the staff members are, have some knowledge of hospital routine and in case of disaster will help receive casualties, tag them with name and other essential information, run errands to the various departments and receive the relatives of the injured.

Another group that works in the central service department has built up a reserve of dressings and supplies in anticipation of an emergency and is ready to volunteer for a heavy schedule in case of a catastrophe.

The dynamic Mrs. H. G. McLee, a former teacher, is at the helm.

## How Rochester Aides Work

Younger members of the aide service at Rochester General Hospital, Rochester, N. Y., serve as messengers; older members, as hostesses. During the summer college students make eager and efficient volunteers. Shown in the photograph are two messengers with their noiseless express wagon loaded with records and flowers.

This aide service has membership in the department of volunteers of the local council of social agencies and sends delegates to the council's four meetings held each year. The council has arranged for an annual course in community organization, under the auspices of the University of Rochester, and all hospital volunteers are urged to take it. The general secretary of the


council of social agencies conducts the course.

Another Rochester innovation is the hospital library council. Under the guidance of the Rochester Public Library this council has been formed. Its membership includes all hospital library aides in the city and members of the staff of the public library.

Once a year an institute is held for new library aides. Required reading for these aides includes Kathleen Jones' "Hospital Libraries," the "Hospital Book Guide" and the *Library Journal*.

## Manual of Good Will

On the day the first robin appeared on the hospital grounds, another messenger of good will appeared at Montefiore Hospital, New York City. It was the carefully planned "Manual for Volunteer Aides" prepared by the department of volunteer service of which Mrs. Monroe C. Gutman is chairman.

Said Dr. E. M. Bluestone, in his foreword to the manual: "We know you are spending precious time, energy and, sometimes, money in rendering this kind of service to our patients and we want you to know that we appreciate what you are doing."

These volunteer aides are under the United Hospital Fund. They receive the volunteer service pin award of the fund when they have given 150 hours of satisfactory service within a year. For each additional 500 hours of service rendered within a two year period a volunteer gets a bar appended to her pin.

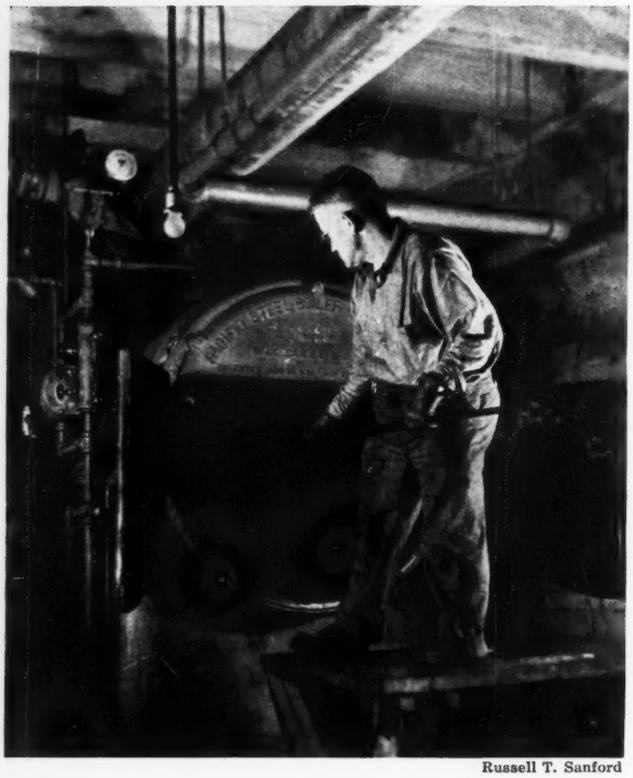
To get back to Montefiore's new manual, it gives rules of behavior, warnings against gossip, rules in regard to food that may be brought patients and facts on the care and cost of uniforms, provision for meals, hours and absences, lockers, personal telephone calls, identification cards, cases of injury and infection and air raid casualties.

The manual, which is very well set up and has a handsomely designed gray cover, was printed by the patients at the Montefiore Hospital Country Sanatorium.

## Doll Housing Project

Already at work on the 1943 model of its doll house, Cedar Branch of the Children's Hospital of the East Bay, Oakland, Calif., hopes to produce another such little gem as the one some little girl received last Christmas. The 1942 model, designed by Nelda Fisher, was a copy of an Early American home, the sort that the sea captains of Nantucket came home to after a whaling trip.

So complete was it in authentic detail that the dishes in the corner cupboard were hand painted copies of old Canton china. There were real doughnuts on the table, shellacked and then "sugared" with talcum powder. Rugs were made by the Branch members in the Colonial tradition. On the roof was a "captain's walk." It will be hard for this year's designer to surpass or equal the Colonial house.



Russell T. Sanford

# *To make the most of* FUEL

**CHARLES A. FULLER**

CONSULTING MECHANICAL ENGINEER, NEW YORK CITY

**It's simpler to clean a tubular boiler than a cast-iron sectional one, but it is a job that should be done once a week at the least.**

AMONG the lasting benefits that undoubtedly will come as a result of the present war will be lessons on better economy in the use of the vast resources of our country.

Foremost among these lessons and one that comes close to the average person is the economic use of fuel for heating purposes. Formerly there was an overabundance of comparatively inexpensive fuel, both oil and coal, so that the first consideration was comfort. Unfortunately, economy was relegated to a secondary position. Economy of fuel is now of primary importance.

Fuel saving in hospitals should start with the boiler plant, where several items should be given careful consideration. All of the heating surfaces of the boilers that are in contact with the products of combustion on one side and with water on the other should be kept clean, as an accumulation of soot or scale greatly reduces the heat transfer through the metal. Periodic cleaning of these surfaces should be made once every week, at least.

With steel tubular boilers this is a fairly simple matter as the major portion of the heating surface consists of circular tubes and the cleaning can be accomplished easily with the use of flue brushes. With cast-iron sectional boilers, generally speaking, the surfaces are uneven, and considerably more work is required to remove the soot.

Another point that bears on the efficiency of a boiler is the condition of the water within the boiler itself. Frequently the accumulation of oil and sediment within the system forms a film over the surface of the water in the boiler. This interferes materially with the production of steam and causes a foaming condition. When this condition exists, it is often necessary to maintain a considerably higher pressure to produce proper circulation, and various sections of the heating system become sluggish in circulation because of a large quantity of water being carried over into the piping system along with the steam.

A simple method of determining whether or not such a condition exists is to draw off a small quantity of the water near the surface. This can usually be done through the blow-off connection at the bottom of the gauge glass. If this water is boiled violently in an open pan, indication of foaming will be seen.

To correct this difficulty, the best method is a thorough surface blow, which can be accomplished easily if the boilers are equipped with surface blow-off connections. If not, it is a simple matter to remove the safety valve and attach a pipe with a connection to the nearest drain and give the boiler a surface blow through this connection. This is done by allowing cold water to enter the feed line, the excess water being discharged through the surface blow-off connection.

The trouble may also be greatly relieved by the application of some of the better known boiler compounds. These will also to a great extent eliminate rusting on the inner surface of the boiler tubes and surfaces.

Another source of fuel waste is oftentimes encountered in leaks through the boiler setting or, with cast-iron sectional boilers, between the sections. Any leakage of air beyond the fire bed causes a decrease in the temperature of the flue gases because of the infiltration of cold air and a consequent decrease in combustion efficiency. The presence of such leaks can be readily determined with the use of a lighted candle held close to the boiler surface or setting. Any leaks will be indicated by the flame being drawn in.

With hand firing of coal it will be found that with the use of smaller grades of coal, such as No. 1 or No. 2 Buckwheat, best economy will be obtained with frequent firing and a thin layer of coal spread evenly over the fuel bed. Care should be taken to see that no holes are burned

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(Signed) SUPERINTENDENT

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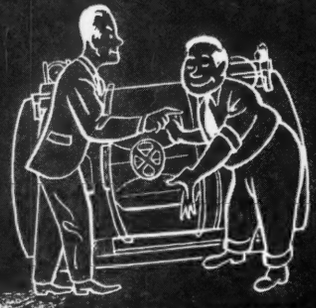
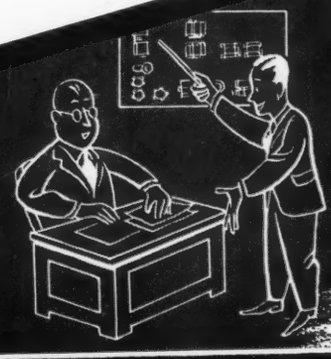


INSTRUCTION OF NEW WORKERS



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through this fuel bed as this again would result in surplus air being mixed with the products of combustion.

With oil firing the proper mixture of oil and air is of utmost importance in maintaining the highest efficiency. This can be determined safely only by means of flue gas analysis. While it has generally been assumed that analyses of flue gases can be done only by experts, there are now on the market instruments that can be used efficiently by the average fireman with some simple instructions. These instruments are easy to operate; the percentage of $CO_2$ is the important factor to be determined. If no recording instrument to determine flue gas analysis is available, the purchase of one would be a good investment in any plant of reasonable size.

Periodic readings should be made and reports given to those in authority regarding $CO_2$ content of the flue gases. Together with this instrument there should also be a stack thermometer for reading the temperature of flue gases. A flue gas content of from 10 to 12 per cent is generally considered fair economy. The higher the $CO_2$ content with a resultant moderately low flue temperature, the higher will be the efficiency. A $CO_2$ content of less than the foregoing figures usually indicates an improper mixture of air and oil.

### Maintain a Constant Draft

With a little practice and instruction the average attendant should be able to make proper adjustments to maintain an efficiently operating oil burner. A stack temperature of from 400° to 500° F. is considered well within the margin of good operating efficiency. High stack temperatures generally indicate one of two things: an excess accumulation of soot on the boiler surface or a short-circuiting of the flue gases through improper application of baffles or leaks in the internal portion of the boiler setting.

The proper amount of draft is an important factor in the operation of the boiler plant. With coal firing an excess draft may prove as detrimental to the plant efficiency as insufficient draft. The uptake dampers on the boilers should be closed as much as possible and still maintain the maximum load requirements on the boiler plant.

Most essential is the maintenance of a constant draft, as variations in the intensity would tend to change the mixture of air and oil and, therefore, upset previously adjusted apparatus.

Each plant operating with oil burners should be provided with an automatic draft adjuster in the breaching at the point at which it enters the chimney. This is of particular importance because of the fact that varying wind velocities change the draft intensity in the stack. With an automatic draft adjuster properly set, the draft intensity in the combustion chamber will be automatically maintained at the proper point.

### Prevent Excessive Steam Pressures

Another point to consider is steam pressure maintenance. It is advisable, generally speaking, to maintain as low a pressure as possible and still produce proper circulation throughout the entire system. Excessive pressures tend to overheat various sections of the building and, furthermore, to increase losses of steam, particularly through the return system. It is important to set dampers and control devices at the lowest possible point and to see that this apparatus is kept in a satisfactory working condition.

Another important consideration in connection with a steam plant is uneven heating, certain sections of the building being located at a considerable distance from the boiler plant.

With hot water systems this can be readily overcome by proper adjustment of circulation valves but with the steam system it is not so simple. Naturally, the sections nearer the boiler plant will receive the steam sooner than the farther sections. This means either that the near sections are overheated or that the boiler plant must be started to operate earlier in order to bring the remote sections up to temperature at the required time.

With vacuum systems, when vacuum pumps are used to induce circulation, uneven heating can frequently be overcome by installing valves on the various branch lines and adjusting the valves to restrict the flow on the shorter lines. Another method lies in the use of zone valves or motorized valves controlled by thermostats located at proper points in the sections so controlled.

Uneven heating also may result from improper installation of the piping system, causing traps or restrictions in the lines and thereby requiring a greater steam pressure on the boiler plant to accomplish proper circulation in certain sections. Frequently it will be found that by some simple change or modification of the piping system these difficulties may be overcome. If such conditions exist, it would be well to engage the services of an expert to locate the difficulties and to recommend changes.

With vacuum systems it is essential to keep careful check on the thermostatic return valves installed on the return of each radiator and heating unit. These valves are constructed with a thermostatic element containing a liquid the function of which is to vaporize at the required temperature and thus close the valve against the passage of steam into the return system. Frequently after a few years' operation this liquid will escape and the valve become inoperative. This will result in the loss of steam through the return system. Furthermore, it interferes with the proper functioning of the remaining portion of the system.

### Keep Check on Ventilating System

In buildings in which ventilating systems are installed a considerable saving may be realized by a careful check on methods of operation. When the system is needed to supply heat as well as ventilation, it is of primary importance to provide means of recirculation for the warming-up periods. In other words, instead of bringing in outside air, which naturally requires an excessive amount of heat during the warming-up period before the building is occupied, if the air within the room can be recirculated, this warming-up period will be materially shortened and at the same time a considerable amount of fuel saved. The reverse of this is naturally true in connection with shutting down the ventilating system as soon as the requirements in the rooms occupied have ceased. This applies particularly to public areas.

The same situation holds for exhaust systems. These should be operated only during necessary periods, as infiltration through windows and doors is greatly increased when the exhaust system is in operation.

## ENGINEERS' QUESTION BOX

### Why Do Dressings Mildew?

**Question 20: What causes mildew on dressings that have just been sterilized?—E.F., Ga.**

ANSWER: This is caused (1) when the sterilizer or autoclave is opened too quickly after sterilizing, thus causing steam to condense on the dressings instead of escaping through the vent, or (2) when dressings are removed too soon from the sterilizer or autoclave. Dressings should be given time to dry out before they are removed.—EMMY LEHMANN, R.N. *central supply room supervisor, Strong Memorial Hospital, Rochester, N. Y.*

### AMMONIA LEAK ANSWER WINS

"What tests should I use for leaks in the ammonia line? For leaks in freon lines?" This question, which was answered last month by E. W. Riesbeck, consulting and construction engineer of Chicago, won him the monthly $5 prize. Other hospital engineers are invited to send in their problems or their solutions to other problems. Here are some questions that still need to be answered:

**29. What are the best temperature and humidity for an air-conditioned operating room? An air-conditioned nursery?—W.F.A., N.J.**

**31. Can we save money by using heat reclaimers in the discharge water from the washers in the laundry?—F.B., Ill.**

**33. How would you test thermostatic radiator traps?—W.J.M., Ohio.**

### Using Wall-Washing Machines

**Question 8: With sponges now selling at about $15 a pound would this be a good time to use wall-washing machines?—N.T., Mass.**

ANSWER 1: Judging from my own experience, washing machines have not been satisfactory in hospital work. Handwork is required around lavatories, closet bowls, doors, windows, sinks and cabinets. We have used old towels, heavy pads or other materials from the linen room for washing walls with good results. Material is folded and stitched around three sides. The painter grasps it in the center when washing. This sponge has been satisfactory and holds up for two or three rooms when used on both sides.—E. W. RIESBECK, *consulting and construction engineer, Chicago.*

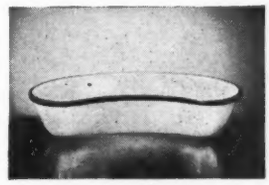
ANSWER 2: Wall-washing machines have been in use in many hospitals for several years. The consensus is that they do a better and quicker job than is possible with sponges and the workmen usually prefer to use a machine. When walls are rough, however, the machine is less satisfactory.—FLORENCE J. SCHAEFER, *housekeeper, Strong Memorial Hospital, Rochester, N. Y.*


# Red Riding Hood Was Very Good!

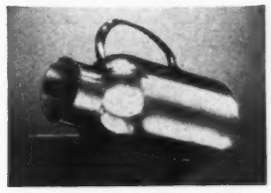
● *Yes, little Red Riding Hood was a good-good girl but she didn't see so well. She certainly should have seen the Wolf in Grandma's clothing . . . we're sure that others would.*

● People *today* are observant. They notice the little things and judge you by them. For example, your patients and physicians judge you by the quality of your kitchen and clinical ware. If it's Vollrath, they know that yours is an institution where the finest is used. Realizing the importance of quality, leading hospitals from Coast-to-Coast insist upon Vollrath kitchen and clinical ware. They know that Vollrath Ware is designed for beauty and utility and is built for long life. Since 1874—*sixty-nine years ago*—Vollrath has maintained its well-earned leadership. We urge you to investigate.

*Vollrath NuSteel Liquid Cleaner*



*Porcelain Enameled Pus Basin*



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# HOUSEKEEPING PROCEDURES

**Conducted by Alta M. LaBelle**

### Who's in Charge?

On the sometimes vexing question: "should the housekeeper have complete charge of the maids or should the nursing supervisor or head nurse discharge part of the supervisory duties?" Mrs. Hertha McCully of Chicago's new Wesley Memorial Hospital votes emphatically for the housekeeper. However, she adds this reservation:

"I do think that the housekeeping department should not be resentful of any suggestions or criticisms offered by the nursing supervisor. After all, she has closer contact with the patient than has any housekeeping department employe and is more likely to hear any complaint the patient has to make. It is the mutual aim of both the nursing and housekeeping departments to make the patient as happy and comfortable as possible and we must work together in order to accomplish it."

It seems far more satisfactory for the nursing supervisor to take up any problems with the housekeeper and leave it to her to give directions to her staff, in the opinion of Mrs. Augusta B. Sullivan, former executive housekeeper of St. Luke's Hospital, Marquette, Mich.

"No employe works well under two directors," Mrs. Sullivan contends, "and, furthermore, he has pride in his own department and does not like to feel that he is subject to the authority of another department head."

It is up to the housekeeper, too, to encourage a helpful spirit of cooperation among departments, without which no department or institution can be successfully operated, Mrs. Sullivan feels.



### HELP WANTED

**"How can one possibly keep wax on the linoleum in such rooms as diet kitchens and doctors' shower rooms? Our corridors and office floors shine, but these rooms worry me." C.W., Ill.**

• •

If you know the answer to this one, please send it along to the Housekeepers' Corner. And if you have a problem of your own, send that along, too. Doubtless, somebody in the housekeeping field knows the answer and will be glad to share her knowledge.

### Education Reduces Waste

At MacNeal Memorial Hospital, Berwyn, Ill., Orpha Daly, the executive housekeeper, has found that "education and more education" of both the housekeeping employes and the nurses is the only way to reduce the waste of cleaning materials, tools and linens. But let her tell it herself:

"I try to teach each employe the proper amount of cleaning material required to accomplish the best work—in the easiest way. I have one person issue cleaning material and keep a record of it, which I check. Dust mops, brooms and brushes are issued on an exchange basis and I make it a point to tell my employes the cost of many articles. This helps to make them conscious of the value of their equipment and they do take better care of it.

"Linen is another problem and can be solved only by constant watchfulness and cooperation among the nursing staff, the linen room and the laundry. Keep the thought uppermost that you want everyone to have all that is needed to give proper nursing care or to do a good job of cleaning, but that if it is

wasted it will be costly to the employe in the final analysis by boosting operating costs. Therefore, if a saving is made it will mean more salary for the employe or an extra worker when one is needed.

"Owing to present shortages one can usually make employes understand that if an item is wasted today, they may have to do without it entirely until the end of the war."

• •

### What About Carpenters?

Another one of those jurisdictional disputes that sometimes arise in the best regulated hospitals concerns the painters, carpenters and upholsterers. In some instances these employes are part of the engineering department, in others, of the housekeeping division.

At Sherman Hospital, Elgin, Ill., Cora Wicklund, the executive housekeeper, advises that carpenters and painters come under the housekeeper's supervision inasmuch as this type of work is closely related with that of the housekeeping department.

"Our engineer could not possibly assume responsibility for all this detail work. However, in large hospitals I think these men should be under the supervision of the engineer who should work closely with the housekeeper."

At Sherman Hospital, incidentally, Miss Wicklund has found that work schedules are most satisfactory if they are arranged about twenty-four hours ahead. This assures work for the carpenters and painters and still allows time for extra jobs that must be done immediately.

"The cleaning maids have a regular schedule so after they have been with us for a few weeks I only check their floors to see that the work is being done correctly."

• •

### Keep on Analyzing Jobs

Hospital occupancy is up—hospital personnel is down and when is the housekeeper going to find time or strength to make job analyses these days? However, in the opinion of Mrs. Hertha McCully, executive housekeeper at Wesley Memorial Hospital, Chicago, job analyses are more important now than they ever were before, in view of the present turnover of help.

It is necessary that the executive housekeeper and her supervisory staff be thoroughly familiar with the component parts of each job so that it can be efficiently supervised.

"Right now I should say that each job should be analyzed once a month because so many duties are being combined, which necessitates constant changes in work schedules."

Organization charts, Mrs. McCully believes, are particularly valuable in drawing the line of demarcation between the duties of the housekeeping and those of nursing departments.

"It is of benefit to the supervisors especially to have accurate charts outlining duties and responsibilities of the housekeeping department."

In agreement with Mrs. McCully's views, Mrs. Augusta B. Sullivan, former executive housekeeper at St. Luke's Hospital, Marquette, Mich., points out that in order for the housekeeper really to know her task it is essential for her to make a job analysis for her particular location and staff.

"Much depends on the ability and the permanence of her staff as to how often this analysis is necessary, but the alert housekeeper will be aware at once of any letdown in efficiency and will recognize the need of re-analyzing her work.

"What the job analysis does for the housekeeper, the organization chart does for her staff. However menial the task, any worker likes to know exactly what is expected of him. Charts placed in conspicuous spots keep each member of the staff informed as to his individual responsibilities and duties. Loyal employes will appreciate this chart and undesirable ones will be shown up by it."


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# *Having Menu Trouble?*

# HERBS will HELP

WHILE bemoaning our losses in the ingredients that make up our favorite dishes, we should also be counting our blessings—herbs among others. Yet how few of us recognize the magic that lies in these modest little plants, some of which we would never notice were it not for the tangy scent when the wind is in the right direction or when raindrops stand on their leaves. They may tempt us to crush their foliage between a thumb and forefinger until our sensory appetites become satiated with their fragrance, but seldom does our imagination prompt us to investigate further.

### Herb Growing a Lost Art

The loving care that our grandmothers bestowed upon their herb gardens has been lost during the years. Only the oldsters can recall the savory bags that hung in the pantry or the tender sprouts that were carefully spread out to dry in the warm sun. Grandmother knew instinctively where a bit of sage, sorrel and basil would help, would make the dish inviting. She needed no requisitions to assure them a place in her cupboard. They grew at her doorstep.

Although food planners today have still more resources on which to draw than our grandmothers, there is evidence that they are reviving the herb garden. Food habits must change to conform with war-time rationing. Dishes that once were scorned now, because of circumstances, occupy major positions on the menu. And herbs can give them new zest.

One of the great advantages of herbs is that they can be grown practically at the kitchen door. They require little care, many of them at least, and will repay many times over any attentions bestowed upon them.

They are of two varieties—annuals and perennials. Harvesting goes on all through the summer as each herb in turn matures its flowers and fruits. The leaves of the perennial herbs can also be gathered whenever the plants are pruned. The best time to pick the leaves is just before flowering, for then they are richest in the essential oils.

In drying herbs the leaves are gathered on dry, breezy days, only the young and perfect leaves being selected for this purpose. If it has rained the day before, it is not necessary to wash them. Tender budding tops are frequently added. They are then hung in bunches and put in paper bags or, preferably, spread out on a cheesecloth, stretched over a window screen. If they are not perfectly dry before storing, they may be put in a slow oven or a warm oven in which the gas has been turned off.

Most popular among the perennial herbs are the following*:

**ATTENTION!**

**For last minute information on food rationing, priorities on food service equipment and other developments of interest to dietitians see "Headline News" (p. 49) and general news (p. 120).**

SAGE, *Salvia officinalis,* a hardy gray-green bushy herb. It blooms in June with purple flowers. Sage can be layered or the side roots can be pulled out and reset to make more plants. The dried and powdered leaves are chiefly used in poultry dressing, either alone or with parsley or other spices. The fresh leaves can be used for the same purpose until late fall and can also be chopped and added to cream cheese balls. Sage tea, too, is a pleasant and wholesome summer drink.

WINTER SAVORY, *Satureia montana,* a small bushy herb, that can be increased by division of the roots in the spring. The leaves, dried and powdered (or fresh), are added to mixed herbs for seasoning. A very little, either fresh or dried, may be added to the pot of beans or peas when they are almost cooked.

BURNET, *Sanguisorba,* is a soft-leaved herb with rosy brown flowers shaped like raspberries at the tops of slender stalks. The young and tender leaves are put in salads. They have a mild flavor of cucumber and are an important ingredient of herb vinegars.

CHIVES, *Allium schoenoprasum,* are bulbous plants with leaves like hollow green needles and have a delicate flavor of onion. They increase rapidly and can be divided. The chopped leaves are good in any salad and in any dish in which a suspicion of onion is acceptable. They are put in omelets with other herbs and with or without tarragon in potato salad, in cream cheese balls and in sandwiches.

MINTS, *Mentha,* can be had in sev-

*These lists compiled by Annie B. Carter, Plainfield, N. J.

eral varieties and all are useful. Spearmint is the well-known variety that is used in mint sauce for lamb and in iced tea, but the others are just as good and have different flavors. Peppermint is delicious in fruit cups and iced tea or for candied leaves. For those who like it in tea, a leaf of each variety may be crushed with sugar with the tea leaves in the teapot.

TARRAGON, *Artemisia dracunculus.* True tarragon must be bought from a nursery for it does not set seed. The fresh leaves, chopped, are good in salads, omelets, tomato cocktail and in meat and egg salads. To make tarragon vinegar, fill a fruit jar with the crushed and torn leaves and pour over them vinegar just brought to a boil; let stand for several weeks, then strain and bottle. White wine vinegar is said to be the best for tarragon but is not necessary.

Tarragon grows best in good soil and partial shade. It needs winter protection and should then be cut back almost to the ground and covered with salt hay and leaves.

THYME, *Thymus.* There are many varieties of thyme, each with a unique spice. The fresh leaves are put in omelets and stuffed eggs, in sauces and with vegetables and meats. The dried leaves are used in much the same way and in mixed herbs for poultry dressing.

LEMON BALM, *Melissa officinalis.* Lemon balm grows a foot high and spreads rapidly. The dried leaves are mixed with other herbs for their strong lemon scent. Iced balm tea, like sage tea, is a quite palatable beverage.

LOVAGE, *Levisticum officinale,* is a tall growing herb. The leaves and stems have a strong flavor of celery and can be used in cooking in place of celery. The leaves, both fresh and dried, are put in soups and stews.

FENNEL, *Foeniculum vulgare,* although listed as a perennial, is not hardy. Both leaves and seeds are useful. The fresh leaves are chopped and put in a sauce for fish or in melted butter or they can be cooked with the fish. Dried leaves can also be used in this way. Seeds may be scattered over fish or they may be cooked with it.

Among the annual herbs that bear investigation are:

BASIL, *Ocimum basilicum,* a useful herb that is easily grown from seed. Seeds sown outdoors in May do not mature until midsummer. Basil is an ingredient of many Italian dishes. The fresh leaves are put in stewed tomatoes, in sauce for sphagetti, in tomato cocktail, in a mock turtle soup, in bean soup and in herb vinegars. A few tender leaves may be used in salads and sandwiches. The dried herb has little flavor. Basil vinegar is made with garlic.

BORAGE, *Borago officinalis.* A gray-leaved sprawling herb that comes easily from seed. Borage is a good vegetable, cooked and eaten in the same way as spinach, or it may be added to spinach. The juice of the cooked leaves with some chopped leaves added is good in a thin potato soup.

Iced tea and lemonade also are given a fine and unusual flavor with the juice of borage. The tiny blue elfin flowers are put in iced drinks and scattered over a salad for a garnish. They may also be candied. Borage will usually seed itself, but it is as well to sow seed aplenty if one is planning to use it for a vegetable.

SWEET MARJORAM, *Origanum marjoram.* It is best to sow seed in the house or cold frame in the early spring for marjoram requires two months to mature. An easier way is to buy a few plants. The fresh leaves, chopped, are put with other herbs in soups, stews and omelets. The dried herb, powdered, is put in "kitchen bouquet" and in stuffings for meats.

PARSLEY. The many uses for this herb are well known. If it is too much trouble to raise the several varieties from seed, plants can be bought. Parsley is biennial but can be carried over the second year if given winter protection and it often seeds itself. Constant care must be taken to keep it cut, or else it will go to seed.

SORREL, *Rumex scutatus.* This is a French sorrel, Oseille, and one of the best. Some varieties are perennial, others annual, but all grow easily from seed and in an old open cold frame they seed themselves. In France sorrel is constantly used in soups, ragouts and fricassees and is boiled like spinach. Sorrel soup is extremely good and one can choose from several recipes.

FLORENCE FENNEL, *Foeniculum dulce, Finochio.* The stem thickens at the base and this part is cut up and boiled for a vegetable and served with a cream sauce. The Italians also eat it raw, like celery. It has a decided flavor of anise, which some people do not like.

ANISE, *Pimpinella anisum.* An herb used only for its seeds. Anise is slow in maturing and seeds should be sown, if possible, in the house or in a cold frame. The seeds are used in cakes, in applesauce and in cream cheese. Aniseed tea is heartening and warming, with a strong aroma that is pleasing.

CHERVIL, *Anthriscus cerefolium.* This variety grows easily from seed but should be in a shady spot, for hot midsummer sun works havoc with it. A teaspoon of minced chervil is good in almost any salad. It can be added to mayonnaise, alone or with other herbs. Chervil is good in any cream soup and in melted butter or fish and meat. It is cooked with eggs, either fresh or dried. When dried and powdered, it is put with "fines herbes." The light green leaves are useful to garnish a dish as a change from the universal parsley.

DILL, *Anethum graveolens.* The seed is sown out of doors about the first of May. The plants grow 2 feet high or more. Dill has blue-green, thread-like leaves and umbels of yellow flowers. The seeds taste a little like anise. They are well known in dill pickles. Dill vinegar is made by pouring vinegar over the seed. The leaves and also the opening buds are put in sauces and gravies to flavor fish and meat, boiled lamb or chicken. The stock of lamb stew, or any stock, can be thickened with flour and vinegar and the finely cut fresh dill. The chopped leaves are good in potato salad with tarragon and chives and in other salads, too. Unlike most seeds, those of dill are planted ½ inch deep. Once grown, dill self-sows from year to year.

CARAWAY, *Carum carvi.* This herb matures early in the season. The second year, it grows 2 feet tall and is topped with umbels of white florets, and then begins to set seed. Thereafter, it seeds itself freely from year to year. The root resembles that of the parsnip and in former times was boiled and eaten. Nowadays, caraway seed is often used in cookies and cakes. The seeds are also put in soups and stews and in dishes of apples, both baked and made into pie.

# Aides for the Dietitian

IN CONJUNCTION with the American Dietetic Association, the American Red Cross has assumed responsibility for a volunteer dietitian's aide program to help relieve the growing shortage of dietitians and trained lay assistants in hospitals.

The Red Cross has expanded the training of its volunteers in nutrition and has organized a volunteer dietitian's aide corps as one of its volunteer special services.

A volunteer dietitian's aid is a woman who is trained under the Red Cross nutrition service to assist a qualified dietitian. She may accept no remuneration of any kind for her services. She must work under the supervision of and as assistant to a qualified dietitian, never as an independent worker. The service is not to supplant that given by paid workers but is to be supplementary to it.

### Who Can Be an Aide

In order to qualify for membership in the corps the applicant must be a United States citizen, 18 years of age or over and in good physical condition. She must have a high school education or its equivalent (the latter to be evaluated by a volunteer dietitian's aide committee in view of the applicant's training, experience and personal qualifications). In addition, the applicant must have completed the standard twenty hour nutrition course or its equivalent and the forty hour dietitian's aide course.

Every aide must be willing to serve without remuneration; to meet the regulations of the hospital to which she is assigned; to give 150 hours' minimum yearly service, preferably in a three months' period, and to serve in emergencies in local hospitals for as long as she is needed.

A volunteer special service certificate will be issued for each aide who becomes a member of the corps.

Canteen Corps members who are not assigned to a mass feeding project and are not subject to emergency call are eligible for the dietitian's aide course, provided the other requirements for membership are met.

The Red Cross volunteer dietitian's aide committee and the Red Cross nutrition committee will determine jointly what additional training, if any, may be needed by canteen corps members and nutrition aides who may already be working in hospitals in order that they may qualify as volunteer dietitian's aides.

The dietitian's aide is authorized to perform only those duties that are under the supervision of the dietitian and subject to the approval of the hospital administration. She may not participate in any commercial service units connected with the hospital, such as a cafeteria or dining room. The range of her duties may include the following:

**Food Preparation:** (1) Make coffee; (2) prepare eggs and toast; (3) prepare nourishments and special feedings; (4) prepare foods for special diets; (5) prepare vegetables and fruits; (6) make salads; (7) make desserts.

**Food Service to Patients:** (1) Pour and serve nourishments; (2) set up trays, *i.e.* check dish and silver arrangements, tray, card and menu; (3) check food received on food trucks; (4) prepare cold foods for service and place on trays; (5) weigh food for special diets; (6) serve hot foods on trays; (7) check trays with patients' menus; (8) carry trays to patients; (9) return trays to pantry and check and record waste on specified items; (10) strip trays, stack dishes and run through dishwasher.

**Food Service to Personnel:** (1) Check in foods and supplies to dining room; (2) prepare cold foods for service and arrange on counter desserts, butter, cream, fruit juices, milk, breads and salads; (3) turn on steam and arrange foods on hot counter; (4) put out proper serving utensils; (5) serve on counter during meal; (6) put away food and assist with cleaning counter and equipment.

**Management and Records:** (1) Visit patients with dietitian and record food preferences; (2) write special diets under supervision; (3) summarize food orders; (4) check food and supplies in and out of units; (5) write names of patients on diet or tray cards and menus; (6) label formula bottles; (7) make out orders, records and reports as required; (8) take and record inventories of food, supplies and equipment; (9) check on orderliness and cleanliness of service and preparation units; (10) answer telephone, deliver messages and perform errands; (11) assist in the collection of materials for patients' classes and the setting up of exhibits and assist with demonstrations.

The volunteer dietitian's aide committee, a subcommittee of volunteer special services, is set up in any Red Cross chapter in which there is a need for such a corps. The committee must be representative of professional and lay members of the community and will be responsible for maintaining standards and discipline and for administering and supervising the corps.

Before a dietitian's aide corps can be formed the committee must apply for the approval of the administrator of volunteer special services and the director of nutrition service at the area office. The duties of volunteer dietitian's aides, as agreed upon between the American Red Cross and the American Dietetic Association, must be observed by the local volunteer dietitian's aide committee and by hospitals using the service.

### Hospitals Must Accept Rules

It is required that hospitals using the services of the volunteer dietitian's aide corps be registered by the American Medical Association or approved by the American College of Surgeons, that they must accept the policies and regulations of the American Red Cross and the American Dietetic Association governing the use of dietitian's aides and must provide adequate supervision by a qualified dietitian for the aides.

The dietitian's aide uniform is that of the volunteer special services, *i.e.* commando blue with the volunteer dietitian's aide corps bar and the volunteer special services enrollment pin.

# Tray Covers—to Be or Not to Be

RESTRICTIONS on paper doilies and tray covers mean that some patients at least will be eating their food erelong from trays bereft of any covering whatsoever, or at best a paper napkin folded crosswise. Even where an adequate supply of linen covers exists that old bugaboo *manpower* pops up, this time in the laundry. What is not strictly essential must be put to one side and, when all is said and done, as much as tray covers contribute to the appearance of a tray they cannot be classified as strictly essential.

The first trays to leave the kitchen or pantry in their natural state will be those for semiprivate and ward patients. Undoubtedly, those who receive them will be as philosophical about the matter as the dietitian. As one young woman put it recently: "There'll be less chance of stained trays anyway. Everything is out in the open from this point on."

Linen stocks remain high in many hospitals, according to a recent survey, owing, in some instances, to the generosity of women's boards or committees. However, with too little and too inexperienced help in the laundry and greater wear and tear generally, there is no telling how long they will last. The natural desire is to conserve them. Sensing this situation some dietitians have stocked ahead on paper covers and doilies and will use them while they last.

For the time being at least, the private patient is continuing to receive trays dressed in linen although one cover may have to last longer than formerly and he may have to forego the luxury of a fresh napkin with each meal.

In one large New York City hospital private patients are receiving but one napkin a day, which is kept in the room. At the time this was written they were given a fresh tray cover with each meal but this ruling may have since been changed. It is likely also that paper doilies served under extra nourishments will be discontinued. Indeed, under food rationing, it is possible that extra nourishments will be severely curtailed.

Semiprivate patients in the same hospital receive one linen tray cover daily and one clean napkin. The only exception to this ruling is when either the cover or the napkin becomes noticeably soiled.

This hospital now has nine months' supply of paper goods on hand which it is using in ward tray service. When this stock is exhausted there will be nothing to do but serve the trays without coverings or, as already indicated, with folded paper napkins, which are as yet unrestricted.

Granted that paper tray covers were available in unlimited quantities, there are still problems involving their use as one dietitian recently discovered. Despite a substantial stock of linen she decided to conserve by using paper. She soon found that she didn't have the necessary amount of help to separate the covers, or, to put it more exactly, she lacked the type of help to separate them properly, and her trays were going out padded with four or five paper covers instead of one. Then and there she decided to revert to linen.

In most hospitals the disposition seems to be to utilize what facilities are available and when the time arrives that it is necessary to curtail to do so with an honest explanation.

# Will Tea Be Next?

WHETHER tea will be rationed this year depends, first, on the continued ability to transport it from inland plantations in India and Ceylon to shipping points and, second, on shipping room and actual delivery of the tea in United States ports. Internal difficulties, including a shortage of labor and transportation facilities in India, have caused some delays in the past in getting tea to loading points, according to the Tea Bureau.

Although these difficulties have eased up somewhat during the past few months, it is impossible at this time to predict their future course. As for shipping space, the War Production Board has agreed to provide it for the tea scheduled to be delivered to the United States this year. If the bulk of this tea is landed here safely, it seems now that there should be no necessity for rationing.

In one sense tea has been rationed for about a year, not at the retail points of sale but at the wholesale level of distribution. Late in March 1943, the War Production Board put into effect the Tea Conservation Order which limits the sale of tea at wholesale levels to 50 per cent of normal volume. The full effect of this order is only now beginning to be felt because formerly retailers' stocks were high and they were thus able to sell more than 50 per cent of their former volume. Heavy buying has now reduced the retailers' stocks to a considerable degree.

There is no known way of stretching tea, either by attempting to make two cups of tea out of the amount of tea normally used for making one cup or by adding any other substances to it. It takes one tea ball or one teaspoon of tea leaves to make one cup of tea. In each tea ball or teaspoon of leaves there is only so much caffeine and unique leaf flavor —only enough, in fact, to make one cup. Any attempt to make two cups from one tea ball or one teaspoon of tea leaves will produce something less than a good, refreshing cup of tea. And once the tea has been infused with boiling water, the leaves become exhausted and cannot be used again to make tea.

"If you are using tea balls," the bureau states, "you will soon be getting standard-sized balls measured by government order. Each will contain approximately .08 ounce, or about one teaspoon, which is the required amount of tea for one cup. The water must be at a rapid, bubbling boil before it is poured over the tea ball. This is required in order to be sure that the tightly twisted tea leaves will open fully, thus producing the maximum flavor."

In using packaged loose tea, the first rule is to measure it carefully. The correct measurement is one teaspoon for each cup.

# June Dinner Menus for the Small Hospital

Caroline Herrl

Superintendent, Waukesha Memorial Hospital, Waukesha, Wis.

| Day | Soup or Appetizer | Meat, Fish or Substitute | Potatoes or Substitute | Vegetable | Salad or Relish | Dessert |
|---|---|---|---|---|---|---|
| 1. | Cream of Mushroom Soup | Egg Soufflé | Oven-Browned Potatoes | String Beans | Watercress and Tomato Salad | Tapioca Pudding |
| 2. | Barley Broth | Lamb Chops | Mashed Potatoes | Spinach | Mixed Vegetable Salad | Apple Betty |
| 3. | Cream of Pea Soup | Liver and Bacon | Creamed Potatoes | Asparagus | Celery and Cottage Cheese | Graham Cracker Pudding |
| 4. | Tomato Soup | Baked Trout | Parslied Potatoes | Buttered Carrots | Lettuce, French Dressing | Gelatin |
| 5. | Vegetable Soup | Veal Steak | Mashed Potatoes | Wax Beans | Waldorf Salad | Rice Pudding |
| 6. | Cream of Corn Soup | Baked Ham | Mashed Potatoes | Cauliflower | Asparagus, French Dressing | Chocolate Chip Ice Cream |
| 7. | Spinach Soup | Meat Balls | Spaghetti | Tomatoes | Mixed Fruit Salad | Grape Nut Pudding |
| 8. | Clear Broth | Welsh Rabbit | Baked Potatoes | Fresh Peas | Tossed Salad | Mint Ice Cream |
| 9. | Vegetable Soup | Ham Loaf | Mashed Potatoes | Asparagus | Peach and Cottage Cheese | Cornstarch Pudding |
| 10. | Cream of Carrot Soup | Lamb Stew | Plain Boiled Potatoes | String Beans | Cabbage and Lettuce Salad | Strawberry Shortcake |
| 11. | Barley Broth | Baked Salmon | Mashed Potatoes | Corn | Tomato and Lettuce Salad | Orange Ice |
| 12. | Clear Tomato Soup | Swiss Steak | Mashed Potatoes | Cauliflower | Aspic Salad | Fruit Gelatin |
| 13. | Pea Soup | Chicken à la King | Baked Potatoes | Green Lima Beans | Pineapple Salad | Butterscotch Sundae |
| 14. | Chicken Noodle Soup | Veal Loaf | Escalloped Potatoes | Frozen Peas | Lettuce, Thousand Island Dressing | Lemon Custard |
| 15. | Cream of Corn Soup | Vegetable Plate: Candied Sweets, Broccoli, White Turnips, Cottage Cheese | | | | Strawberry Whip |
| 16. | Broth With Rice | Veal Cutlets | Mashed Potatoes | Green Beans | Perfection Salad | Melon |

Continued on page 104


# Hospitals serve RY-KRISP as bread, toast, crackers


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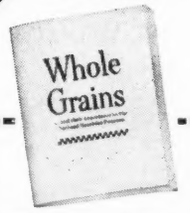


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# June Dinner Menus for the Small Hospital

| Day | Soup or Appetizer | Meat, Fish or Substitute | Potatoes or Substitute | Vegetable | Salad or Relish | Dessert |
|---|---|---|---|---|---|---|
| 17. | Cream of Asparagus Soup | Roast Lamb | Baked Potatoes | Peas | Grapefruit Salad | Blueberry Cobbler |
| 18. | Consommé | Perch | Potatoes au Gratin | Asparagus | Pear, Ginger Ale Gelatin Salad | Baked Custard |
| 19. | Cream of Celery Soup | Beef Stew | Mashed Potatoes | Carrots and Peas | Wilted Lettuce | Bread Pudding |
| 20. | Asparagus Soup | Roast Chicken | Escalloped Potatoes | Spinach | Celery and Olives | Maple Nut Ice Cream |
| 21. | Barley Soup | Roast Leg of Veal | Lyonnaise Potatoes | Buttered Beets | Carrot and Raisin Salad | Prune Whip |
| 22. | Spinach Soup | Baked Salmon With Lemon | Parslied Potatoes | String Beans | Spring Salad | Snow Pudding |
| 23. | Vegetable Soup | Chicken à la King | Mashed Potatoes | Peas | Lime Gelatin and Cream Cheese | Cookies |
| 24. | Cream of Celery Soup | Steak | Baked Potatoes | Tomatoes | Orange Salad | Rhubarb Betty |
| 25. | Cream of Corn Soup | Perch | Escalloped Potatoes | Wax Beans | Grapefruit and Orange Salad | Cherry Upside-Down Cake |
| 26. | Tomato Soup | Veal Birds | Plain Boiled Potatoes | Buttered Fresh Asparagus | Watercress Salad | Bavarian Cream Pudding |
| 27. | Chicken Noodle Soup | Ham | Mashed Potatoes | Buttered Beets | Stuffed Celery | Ice Cream |
| 28. | Watercress Soup | Lamb Chops | Baked Potatoes | Summer Squash | Asparagus Salad | Fruit Gelatin |
| 29. | Cream of Pea Soup | Eggs à la King | Potato Puff | String Green Beans | Mixed Fruit Salad | Date Torte |
| 30. | Norwegian Fruit | Meat Loaf | Creamed Potatoes | Frozen Peas | Perfection Salad | Lemon Ice |

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago

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# Conserve and Control NARCOTICS

**ROGER W. MARQUAND**
PHARMACIST
LAKESIDE UNIVERSITY HOSPITAL, CLEVELAND

ALTHOUGH it seems to be the general opinion that the present system of narcotic control is adequate because little is heard of losses by hospitals and because the government inspectors seem to be satisfied with the procedures now in use, such an attitude seems to me to be quite unsound. It is my feeling that pharmacists in hospitals, where the use of narcotic drugs is concentrated, can do a great deal to enforce more stringent control of them.

One of the cogent arguments for strict control is that because of the war our supplies of raw opium from the Balkans and the Far East have been almost completely cut off and our stock was not too large at the beginning. Add to this the increased needs of the Army and Navy and the greater use because of industrial accidents and we have a condition that calls for well-planned belt-tightening but not for hoarding.

### Prescriptions Must Be Checked

Probably the first thing to consider in preventing theft is the method of filling narcotic prescriptions for outpatients or for any person, including employes, other than patients in the hospital. In Cleveland last fall a notice was sent to retail pharmacies describing a person who was forging narcotic prescriptions. There is no reason why such a thing could not be attempted in a hospital pharmacy to which the public has any access. Consequently, we should always scrutinize the patient and prescription closely and *never* should we fill a prescription written by a doctor whom we do not know or whose handwriting we do not recognize without first getting in touch with him.

Inasmuch as it is an infringement of the federal regulations for a patient to transfer prescribed narcotics to another container, we should also be careful to dispense such tablets in a container in which they will not be crushed and to label the container properly. Article 175 of the federal code states that the dealer who fills a prescription must place on the package a label bearing his name and registry number, the serial number of the prescription, the name and address of the patient, and the name, address and registry number of the doctor prescribing. These points should be strictly followed.

It might be well here to review some of the legal requirements in general. In the first place we must remember that our job is complicated by having both federal and state laws with which to comply. Every pharmacist should have on hand copies of both and should be well versed in their contents. We must remember, too, that compliance with the state law does not excuse infringement of federal regulations, and vice versa.

Primarily, of course, we should see that the hospital is properly registered. Often, owing to a change in routine or through misunderstanding, it will be found the hospital is carrying either excessive or insufficient licenses. A brief reading of section 1 and articles 13 through 20 of the Bureau of Narcotics Regulations No. 5 will enable one to determine the classes of registration required for his needs.

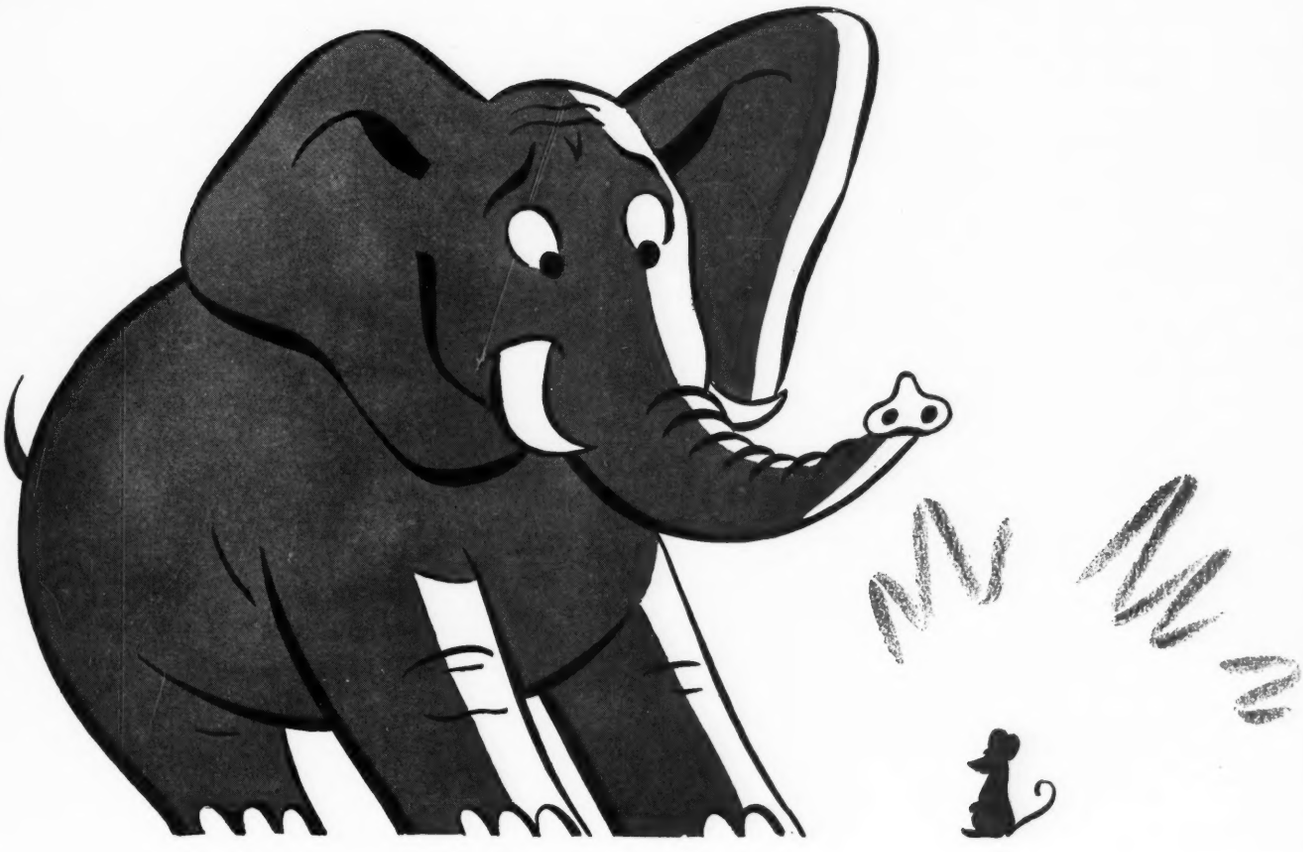
There is a point in these regulations that might help the hospital to conserve its supply of narcotics. Article 15 states that a retailer may supply registered practitioners, on order forms, with aqueous or oleaginous solutions in which the narcotic content does not exceed 20 per cent of the solution in quantities not exceeding one ounce at a time. Apparently, all other narcotic supplies of practitioners must be obtained from wholesalers, a rule that should be strictly practiced in the hospital that does not carry a wholesaler's or manufacturer's registration.

### Packages Must Bear Stamps

Purchasing procedures are uniform and do not warrant discussion here except for a note of precaution about stamped packages. The regulations require each package to bear a canceled stamp covering the contents to be placed thereon by the manufacturer. It requires a tax of 1 cent per ounce or fraction of an ounce on each package and provides a penalty for possession of unstamped packages or packages bearing washed, restored or altered stamps. Therefore, a routine check of new merchandise is in order. To save time and money, the purchaser must be certain of the proper information on the order form, inasmuch as the wholesaler must return an incorrect form.

For dispensing narcotics to patients in the hospital we must carry a class IV or practitioner's license and, according to article 177 of the federal code, "all persons and institutions" so registered "shall keep a daily

Abstracted from a paper presented to the Ohio Society of Hospital Pharmacists, April 1942.



# THE PONDEROUS PACHYDERM AND THE MENACING MOUSE

THE powerful elephant's fear of a tiny mouse is, in some ways, like that of man's fear of those microscopically minute organisms which bring sickness and, sometimes, death. Fear of disease still exists, but the dread of the consequences of many infections has been lessened. This is particularly true of those pathogenic organisms which can be held in check by the sulfonamides.

Such dramatic therapeutic effects have been achieved with the sulfonamides that their use (both orally and topically) has become a routine in military, industrial and civilian practice. Clinical studies involving new methods of application, new products and new techniques, are continuing.

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record showing the kind and quantity of narcotics dispensed or administered, the name and address of each person to whom dispensed or administered, the name and address of person upon whose authority and the purpose for which dispensed or administered." Article 178 continues by saying that the initials of the practitioner ordering the drug should appear on the patient's chart or a separate prescription properly executed should be filed with "the pharmacist in charge of the drug room before the narcotic leaves his control." If both chart and prescription are used the chart should bear a reference to the prescription.

### State Requires a Record

The state law covers this phase in much the same way by stating: "Every person authorized to use narcotics professionally shall keep a record of those received and administered or dispensed otherwise than on a prescription." It is sufficient, however, if a person using small quantities of preparations for local applications keeps a record of the quantity, character and potency of such preparations made up or purchased and date made or purchased without keeping a record of the amount that was applied to each individual patient.

The rules governing exempt preparations are, I think, familiar to all of us with the exception, perhaps, of the following four points: (1) Exempt preparations must contain some agent of medicinal value other than the narcotic used. (2) According to the Ohio state law, no person shall prescribe, administer or dispense to any one person or animal within any forty-eight consecutive hours more than 4 grains of opium, ½ grain of morphine or any of its salts, 2 grains of codeine or any of its salts, ¼ grain of heroin or its salts, or more than one exempt preparation. (3) Use for aural, nasal, ocular, rectal or vaginal purposes is not regarded as external. (4) Manufacturers, producers, compounders or vendors (including dispensing physicians) of exempt preparations shall record all sales or other dispositions at the time of delivery; when such preparations are going to a consumer they shall show the name of the recipient and his address; the name and quantity of the preparation, and the date of delivery. Exempt prescriptions must show date of filling and be kept on narcotic prescription file.

In case of loss through breakage or other accident the person having title thereto shall make affidavit as to the kinds and quantities destroyed and the circumstances involved, and he shall immediately forward such statement to the narcotic district supervisor.

Of course, all records must be kept for a period of two years so as to be readily accessible to inspection by the proper authorities. It might be well, too, if the inspector is not known to you to insist upon his proper identification before any inspection or pick-up of stock occurs. Misrepresentation from this angle would be easy for a thief to accomplish.

In addition, an intern or resident, unless he has a narcotic registry number, cannot prescribe narcotics in the out-patient department, that is, for the patient to take outside of the hospital. He cannot even originate an order for the drugs to be administered to a patient in the hospital. He can write the order only if it was originated by a registered practitioner and it must be later signed by him.

### Records Should Be Uniform

To ensure efficient and thorough control of narcotics by all institutions, I feel that we need a uniform or standardized procedure for maintaining the records. The commissioner of narcotics should prescribe exact procedures to be followed and have printed for the use of pharmacists definite forms on which to keep the records. This would enable us to maintain records as they should be kept and at the same time save time and trouble for both the hospital and the inspector. Because of the lack of such an outline most hospital pharmacists, and probably most hospitals, seem in doubt as to the proper procedure to follow.

I believe it would be best to build such a procedure around a few essential features, namely, a perpetual inventory, individual patient dose record, separate narcotic record book for the divisions and a special narcotic prescription blank.

The perpetual inventory is an especially desirable feature in any adequate system of narcotic control. In the first place, the official regulations require a record of all goods received and dispensed and the inventory would be such a record. Second, official regulations require a three months' report at the request of the collector of the district, the report to include information regarding the amount of goods received during the required period, from whom received and on what date. This information would be readily available on a perpetual inventory. Finally, such a record is a sound economical procedure and helps to catch any so-called leaks at an early stage.

As a further means of control this standard procedure should include periodic checking of ward narcotic stocks, probably about once a month. In lieu of this, Cleveland City Hospital has a narcotic report form to be filled out once a month by each division as a check on its stock. Such a system is to be commended, but a personal inspection by the pharmacist or person responsible for narcotics would be superior.

### Questionnaire Shows Discrepancies

Before this paper was prepared a questionnaire was mailed to 110 hospitals in Ohio to determine current practices. About 50 per cent of the hospitals replied with some significant results. Wherever a pharmacist was on duty he, of course, purchased, stored and dispensed the narcotics. In 23 per cent of the cases the superintendent dispensed them; 40 per cent gave the duty to a nursing supervisor or some designated nurse; 5.5 per cent assigned the task to a physician, and in a little less than 2 per cent of the hospitals some lay person dispensed them.

As for storage, 47 per cent of the reports showed that the drugs were kept in a safe somewhere in the hospital; in 29 per cent of the hospitals they were kept in a locked cupboard in the pharmacy, and in about 11 per cent they were kept just in a locked room.

Whether narcotics were called for or delivered was about evenly divided and in 54 per cent of the hospitals a nurse transported the drugs. In 9 per cent a pharmacist delivered them and in about 13 per cent lay help carried them to the divisions.

Fifty out of the 55 reporting institutions stocked narcotics on the division and three stated they were ordered on individual prescriptions. Of those who stocked them, 20 per cent maintained fewer than 20 tablets,

34.5 per cent kept 20 tablets and 29 per cent had 25 or more tablets in each bottle. Two hospitals apparently use solutions only. Also, 21.8 per cent maintained a reserve supply.

In more than half the institutions no printed forms were used for ordering a supply for the division but in many cases the filled proof-of-use sheet with the empty bottle acted as an order for a new supply.

About 53 per cent of the hospitals handled cocaine solutions for surgery in the same manner as other narcotics. This may or may not be an unnecessary routine. A record of individual doses is not required legally when small quantities are used for local application but, certainly, some sort of record should be maintained to avoid waste.

Approximately 45 per cent of the hospitals do not permit narcotic drugs to be prescribed as home-going medications, a point that might be well worth considering in any plan for conserving our supply.

### More Rigid Control Needed

These reports also gave evidence that in other instances more rigid control over narcotics might be exercised. Such points would include: (1) placing a limit on the number of doses to be given and the time that should elapse before a new order is required; (2) maintaining a record of exempt narcotics dispensed; (3) observing the rule that narcotic suppositories are not exempt preparations, and (4) making a *qualified* physician responsible for narcotic orders and enforcing the rule to the letter.

Thus, these reports show some laxity in handling narcotics which, because of the present emergency, should be overcome both as a patriotic and as an economical measure and also to forestall any unhappy occurrences that might evolve during such a period as this.

Whatever precautions are taken by the pharmacist, I feel that one necessary time-saving step is to incorporate in the hospital formulary and intern's manual a brief but definite explanation of narcotic procedures in the hospital. At City Hospital in Cleveland the full narcotic procedure is also outlined in a book of procedures for use in the pharmacy. This handy reference volume saves much time and indecision for both pharmacists and the medical staff.

# *The Future of Propylene Glycol*

**BRADFORD N. CRAVER**

DEPARTMENT OF PHARMACOLOGY
WAYNE UNIVERSITY COLLEGE OF MEDICINE, DETROIT

IF YOU can't cure it, prevent it! That is a worthy ideal even when you can cure it. This season is a good time to emphasize again the generous, tax-free dividends paid by preventive medicine. Since the pioneer work of Jenner, Semmelweiss, Pasteur, Lister and a host of others, we have come more or less tacitly to accept prevention as the *ne plus ultra* of medicine.

To that end is directed the work of Robertson and his associates. They have shown hat extremely small concentrations of propylene glycol in air gave con[illegible]rotection to mice against air-borne infection by influenzal virus A. It protected as well against air-borne bacterial infection.

Harris and his associates put the method to trial in a convalescent home for children in an effort to prevent cross-infection. They were almost 100 per cent successful. That method of protection has been shown to give better results than ultraviolet irradiation of the air. The apparatus needed for irradiation is costly whereas the propylene glycol can be readily vaporized by simple equipment always at hand in any hospital.

### Glycols Have Bad Reputation

Some years ago an unfortunate experience with diethylene glycol gave the chemical family of glycols a "black sheep" reputation. In chemistry and pharmacology, as in psychology, we must judge each member of a family separately if we would avoid the absurd deductions of an unreasoning bias. Hanzlik and his co-workers more than 10 years ago showed that propylene glycol was nontoxic in concentrations far greater than those needed to prevent air-borne infections. That is a far cry from the diethylene glycol which is metabolized in the body to the extremely toxic end product, oxalic acid.

We should continue to emphasize this distinction lest a false shibboleth brand as a pharmacologic traitor an extremely promising new drug. Lest this emphatic distinction seem enthusiastic but unnecessary, we should recall the editorial written by a prominent physician some years ago that inveighed against the therapeutic use of nicotinic acid amide because it was well known that nicotinic acid was extremely poisonous. More attention to chemistry would prevent such potentially dangerous non sequiturs.

### Solutions of Sulfa Drugs Promising

Although the study of treatment rather than prevention is a less laudable undertaking, in reference to respiratory infections it is certainly still pardonable. For several years the pharmacology department at Wayne University College of Medicine, Detroit, has been investigating the therapeutic usefulness of propylene glycol solutions of the sulfa drugs. They have shown unusual promise in both the treatment and the prophylaxis of the ordinary upper respiratory infections. Their administration with an atomizer has been shown to abort a fair proportion of infections and to decrease materially the morbidity in those that do not receive treatment early enough to avoid entirely the disabling effects of the infection. This use has already been briefly reported. A more extended and carefully controlled investigation of this subject is now in progress.

It is to be hoped that qualified hospital leaders will attempt as rapidly as is feasible to exploit the unusual potentialities of propylene glycol. The prevention of air-borne cross-infections not only in hospitals but also in other public buildings no longer seems like such an unattainable dream. Its realization will be hastened if competent men of vision will lead the way.

# NOTES AND ABSTRACTS

**Conducted by the Staff of the Pharmacology Department
Wayne University, Detroit**

## Pressor Amines and Hypertension

The intensification of interest shown by experimentalists and clinicians in regard to the subject of hypertension is due largely to the demonstration by Dr. Harry Goldblatt and co-workers that hypertension can be produced experimentally by constricting the renal artery. Dr. Irvin Page of Eli Lilly and Company later reported that hypertension could be produced by inducing constriction of the kidney itself with fibrous tissue which forms following application of silk or cellophane to the organ. The type of procedures employed and found to be effective in the production of hypertension immediately suggests that ischemia is intimately related to the development of the hypertensive state. It has been firmly established that the hypertension induced experimentally in animals by the foregoing means is due to humoral factors.

It is possible that under certain conditions, such as the presence of ischemia, decarboxylation of amino-acids supersedes the normal deamination process, thus resulting in the formation of pressor amines which reach the systemic circulation. An appreciable amount of data has accumulated during the past few years which has been interpreted to indicate that at least one cause of arterial hypertension is the formation and liberation of pressor amines by the kidney.

For example, tyrosine may be decarboxylated to the pressor amine tyramine.

Martin recently has supplied additional evidence supporting this theory by demonstrating that rats fed on diets containing from 5 to 10 per cent of l-tyrosine become hypertensive.

In general, the data cited that favor the theory that hypertension is due to pressor amines consist of evidence regarding the formation of pressor amines by kidney tissue and other evidence concerning the destruction or inactivation of the pressor substance. In either case, much of the evidence must be regarded as merely suggestive unless there is unequivocal proof that the pressor substances involved are actually demonstrated to be amines.

*Formation of Pressor Amines.* The *in vitro* experiments reported by the German investigators, Holtz and Heise, revealed that under anaerobic conditions decarboxylase contained in kidney tissue converted a nonpressor substance, dihydroxyphenylalanine (dopa), into hydroxytyramine which exerted pressor activity.

This observation has been confirmed by Bing and Cohen. The latter workers also perfused heparinized blood at a slow rate through the kidney of an isolated kidney-lung preparation and demonstrated that the perfusates collected after the administration of dopa had greater pressor activity than control perfusates collected before the injection of dopa. The duration of the rise in blood pressure subsequent to the injection of perfusates from dopa-injected kidneys was prolonged in the presence of cocaine, thus suggesting that the pressor substance was hydroxytyramine.

Dr. Victor Drill of Princeton University reported that tyramine and isoamylamine were chemically identified as constituents of an extract prepared from renal tissue which had been incubated under anaerobic conditions. Schroeder and Adams of the Rockefeller Institute had previously demonstrated that the

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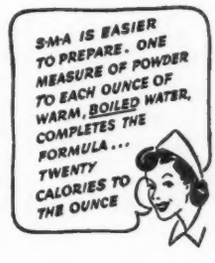


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pressor action of a similar extract was abolished by tyrosinase, an enzyme that causes the oxidation of the phenolic portion of certain pressor amines.

The data obtained from these *in vitro* experiments indicate that under anaerobic conditions kidney tissue is able to form pressor amines from added amino-acids or from materials present in kidney tissue or formed therefrom. This type of evidence merely suggests that a similar mechanism may operate in the kidney under certain pathological or experimentally induced conditions.

Evidence obtained by Bing and Zucker working at Columbia University indicated that a marked pressor response occurred in cats upon restoration of the blood supply to kidneys which had been rendered totally ischemic and injected with dopa from two to four hours previously. It was believed that the pressor substance manufactured from the dopa provided was hydroxytyramine for its presence depended upon the injection of dopa, the pressor substance was heat-stable and ultrafiltrable and its effect was potentiated by cocaine.

The production of a pressor substance from dopa by tissue extracts *in vitro*, by perfused kidneys or by intact kidneys maintained totally ischemic for several hours does not constitute sufficient evidence to prove that the same conversion occurs under pathological or experimental conditions that are compatible with life.

Investigations made under much more physiologically normal conditions by Oster and Sorkin at Mount Sinai Hospital revealed that the injection of dopa into the systemic circulation of hypertensive cats and human beings produced greater pressor responses than could be obtained in the normotensive individuals. One interpretation of such findings is that the kidney of the hypertensive animal readily converts dopa to a pressor substance which is possibly hydroxytyramine. Other interpretations could be made and it is hoped that corroboration and extension of the experimental findings will soon be forthcoming.

*Destruction or Inactivation of Pressor Amines.* Some support for the theory regarding the rôle of pressor amines of renal origin in arterial hypertension could be gained by demonstrating that certain substances specifically inactivate pressor amines *in vitro* and also prove effective in abolishing high blood pressure in hypertensive animals and human beings.

It is a recognized fact that pressor amines can be inactivated in at least two ways. Under aerobic conditions the enzyme *amine-oxidase* found in kidney tissue deaminizes the side chain of pressor amines. Also, the enzyme *tyrosinase* is capable of oxidizing the phenolic portion of the molecule.

Doctor Schroeder and associates at the Rockefeller Institute have attempted to abolish hypertension in experimental animals and man by injecting extracts containing amine-oxidase or tyrosinase. The intravenous administration of tyrosinase isolated from mushrooms in hypertensive rats resulted in significant decreases in blood pressure which often persisted for many days. The authors thought it improbable that the decreases in blood pressure were related to toxic effects of the extract. Similar results were obtained in unanesthetized hypertensive dogs following a single intravenous injection of tyrosinase or repeated injections of smaller doses. The rectal temperature sometimes increased from 1 to 2°C. and when large doses were given bradycardia, vomiting, diarrhea and tenesmus occurred concomitantly with reduction in blood pressure.

Doctor Schroeder injected tyrosinase subcutaneously daily for three or four weeks in 17 patients with arterial hypertension. Good results were claimed in 13 cases that responded with significant decreases in systolic and diastolic blood pressure, relief of symptoms, disappearance of hemorrhagic and exudative lesions in eyegrounds (four patients) and improvement in the cardiac condition.

After cessation of treatment the blood pressure returned to previous high levels in from three to six days. Occasionally, pyrexia developed during treatment and allergic reactions at the site of injection were noted in three patients.

These findings were interpreted to indicate that some phenolic substance concerned with arterial hypertension was altered or destroyed by tyrosinase.

*Treatment With Amine-Oxidase.* Schroeder has also used amine-oxidase to treat hypertension in experimental animals and claims that the blood pressure was consistently lowered in hypertensive rats and dogs. The preparation was somewhat toxic to anesthetized rats but not to unanesthetized dogs. It was recognized that the effectiveness of the extract could have been due to some ingredient other than the amine-oxidase.

The significance of the observations relative to the effectiveness of enzyme preparations in the treatment of clinical or experimental hypertension is fairly difficult to evaluate in view of the fact that febrile responses and toxic manifestations are of frequent occurrence. Investigations conducted by Doctors Chasis, Goldring and Smith revealed the fact that pyrexia is accompanied by reductions in blood pressure.

Furthermore, Prinzmetal et al. of California have recently reported that heat-inactivated tyrosinase preparations administered intramuscularly reduced blood pressure in four patients with malignant or premalignant hypertension. There was definite evidence of decrease in heart size, improvement in eyegrounds and symptomatic relief. The authors point out that the effects on blood pressure were probably nonspecific and referable to protein material which accounts for the untoward reactions noted in the patients, *i.e.* " . . . local inflammatory response and systemic reactions, such as chills and fever of varying degree, perspiration, with general malaise and, rarely, nausea . . . ."

*Chemical Destruction of Pressor Amines.* Means of inactivating pressor amines other than by enzyme action have been sought. Workers associated with Doctor Sobotka at Mount Sinai Hospital in New York developed an experimental approach that was based upon the knowledge that quinones act as catalysts in the oxidative deamination of amino-acids and polypeptides. Orthoquinones formed by oxidation of the cyclic portion of aromatic pressor amines through the action of tyrosinase or supplied to the body by suitable means of administration were believed to form azopheninelike compounds, thus inactivating pressor amines. Furthermore, oxidation of the side chain of the amines would yield aldehydes which can combine with the amino group of pressor amines to form Schiff's base.

Experiments with hypertensive rats revealed that several paraquinones and one orthoquinone were effective in lowering the blood pressure to the normal range (reductions of from 50 to 65 mm. Hg.). Effectiveness was demonstrated with oral and subcutaneous administration. Febrile reactions were not detected but slight local reactions occurred with the use of some of the quinones.

Oster and Sobotka reasoned that more successful experiments could be made with the use of adrenochrome which has the characteristics of a quinone and occurs biologically as an oxidation product of adrenalin. Their preliminary report indicated that adrenochrome was effective in reducing the blood pressure of hypertensive rats and one dog when administered intramuscularly for a few days. No toxic reactions or febrile responses were described. Further studies concerning the effectiveness of adrenochrome in the treatment of hypertension must be made before proper evaluation of the claims can be made.

Although a humoral agent is concerned in the production of experimental hypertension, there is as yet no final proof that the factor involved is a pressor amine which is formed in the kidney. Furthermore, there is as yet no

unequivocal evidence that the therapeutic use of substances which act specifically to destroy pressor amines is really effective in the treatment of human hypertension.—Earl R. Loew, Ph.D.

# CLINICAL BRIEFS

**Conducted by E. M. Bluestone, M.D.**

## Treating Cholecystitis

Acute cholecystitis in the past has been treated according to preconceived plans, most of which were rigid and some of which were contradictory. These plans varied from early, frequently immediate, operation to procrastination until acute symptoms had entirely subsided. However, individualization of treatment has been in use at the Peter Bent Brigham Hospital, Boston, for some years and the results obtained with this method have been reported by Zollinger and Cutler in an article, "Treatment of Acute Cholecystitis: An Evaluation," in the *Journal of the American Medical Association* for Feb. 13, 1943.

The program consists essentially of hospitalization immediately upon establishment of the diagnosis, no matter how slight the signs and symptoms, and careful study of each patient as an individual surgical problem. The accepted conservative measures are first instituted (emergency surgery is rarely necessary) and the signs, symptoms and laboratory data are evaluated at frequent intervals. The cases are divided into three major clinical classifications, depending upon the duration, the severity and the rapidity of progress of the various signs and symptoms. These clinical groups provide the clue to the selection of the proper time for surgery.

The indications for early operation are as follows: (1) a good risk patient seen within 24 to 48 hours of the onset of an attack; (2) exacerbation of symptoms after satisfactory progression under conservative treatment; (3) failure to respond to treatment, and (4) evidences of peritonitis.

Operation is delayed on those patients with diminishing signs and symptoms who are seen late, as well as on elderly or poor risk patients with decreasing signs and symptoms. Advanced age is never a contra-indication to surgery.

Cholecystectomy is preferable to cholecystostomy, though the latter may be done in the few cases which progress rapidly and in which it is considered better to rely on simple drainage.

By these means the mortality was reduced to 2.6 per cent over a period of five years in 146 cases of acute cholecystitis.—Sigmund L. Friedman, M.D.

## Sodium Fluoride Poisoning

During and shortly after the conclusion of a meal of scrambled eggs, 263 patients in the Oregon State Hospital became ill. The symptoms varied from numbness of the mouth through urticaria and abdominal cramps to general collapse and death. Death occurred in most instances within four hours after ingestion of the food.

Because of the explosive occurrence of so many cases, amid inadequate surroundings, treatment had to be empiric and consisted of sodium chloride and warm bicarbonate to induce vomiting and the customary cardiac and respiratory stimulants. Those patients who were less discriminating in their food habits suffered more than the others; those who vomited copiously and promptly suffered the least.

Toxicologic examination revealed uncolored roach powder, which was the source of the sodium fluoride, to have been unevenly distributed in the eggs. This probably accounted for the wide variation in symptomatology.

Lidbeck and Hill, reporting in the *Journal of the American Medical Association* for March 13, 1943, urge distinctive coloring, packaging and labeling of all roach powder containing sodium fluoride.—Sigmund L. Friedman, M.D.

You get up when you're good and ready—maybe play a little shuffleboard, or doze on the beach. At sixty-five, that's the life—or it would be if you weren't a doctor.

America's senior physicians, many of them "retired," are working harder today than ever. In war-crowded cities and towns stripped of adequate medical service, veteran doctors are shouldering the practices and hospital duties of two and three younger men. The nation is deeply indebted to these "grand old soldiers" tirelessly maintaining Public Health during such strenuous times. A soldier can do no more.

Today, happily, the doctor has many new drugs and surgical improvements to help him combat illness and disease on the home front—revolutionary advances unknown to medicine in '17. At hand, too, are the "everyday" yet indispensable medical aids such as U.S.I. Pure Alcohol. The high quality of this product has earned for it not only the confidence of the family doctor, but the respect of the Medical Corps in the field.

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- ☐ Protein Precipitant
- ☐ Spirit Lamps
- ☐ Stains and Reagents
- ☐ Sterilizing Instruments
- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block


**PURE ALCOHOL**

# NEWS IN REVIEW

## Hospitalization Board to Direct Expansion of All Federal Hospitals

BY EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—President Roosevelt has directed that immediate integration and over-all planning for expansion of federal hospitals become the responsibility of the Federal Board of Hospitalization.

The board will be expected to prevent unnecessary duplication of facilities by different agencies in a given area, to consolidate expansion plans, to see that full utilization of existing facilities is accomplished and to exercise control over the general problem of federal hospitalization.

To Harold D. Smith, director of the Bureau of the Budget, the President wrote that comprehensive planning is necessary to avoid overbuilding. A second phase of the planning, he emphasized, must concern itself with postwar requirements and use of hospitals.

The President also dispatched letters to the Secretaries of War and Navy, the Federal Security Administrator and the Administrator of Veterans' Affairs directing that no further hospital or convalescent facilities be acquired within continental United States until each project has been submitted to the Federal Board of Hospitalization.

This prohibition includes expansion of existing federal hospitals, construction of new federal hospitals or contracting for existing buildings, except in situations of epidemics or other emergencies. Recommendations to the President will be cleared by the Bureau of the Budget of which the Federal Board of Hospitalization is a coordinating agency.

Concerning the postwar phase of the planning, Director Smith has asked Gen. Frank T. Hines, chairman of the Federal Board of Hospitalization, to undertake immediately a study of the complete problem of the hospitalization of the veterans of World War II. The study is intended to include determinations as to the types and magnitude of the patient loads and the rate at which they must be provided for; the extent of additional federal hospital facilities, if any, that will be required; the most effective utilization of the entire hospital facilities of the federal government, and the extent to which nonfederal hospital facilities will be available and should be utilized.

In addition to General Hines, the Federal Board of Hospitalization consists of the Surgeon Generals of the Army, Navy and Public Health Service, the key officials of the Veterans' Administration and other federal agencies that operate hospitals. It functions in an advisory capacity to the President.

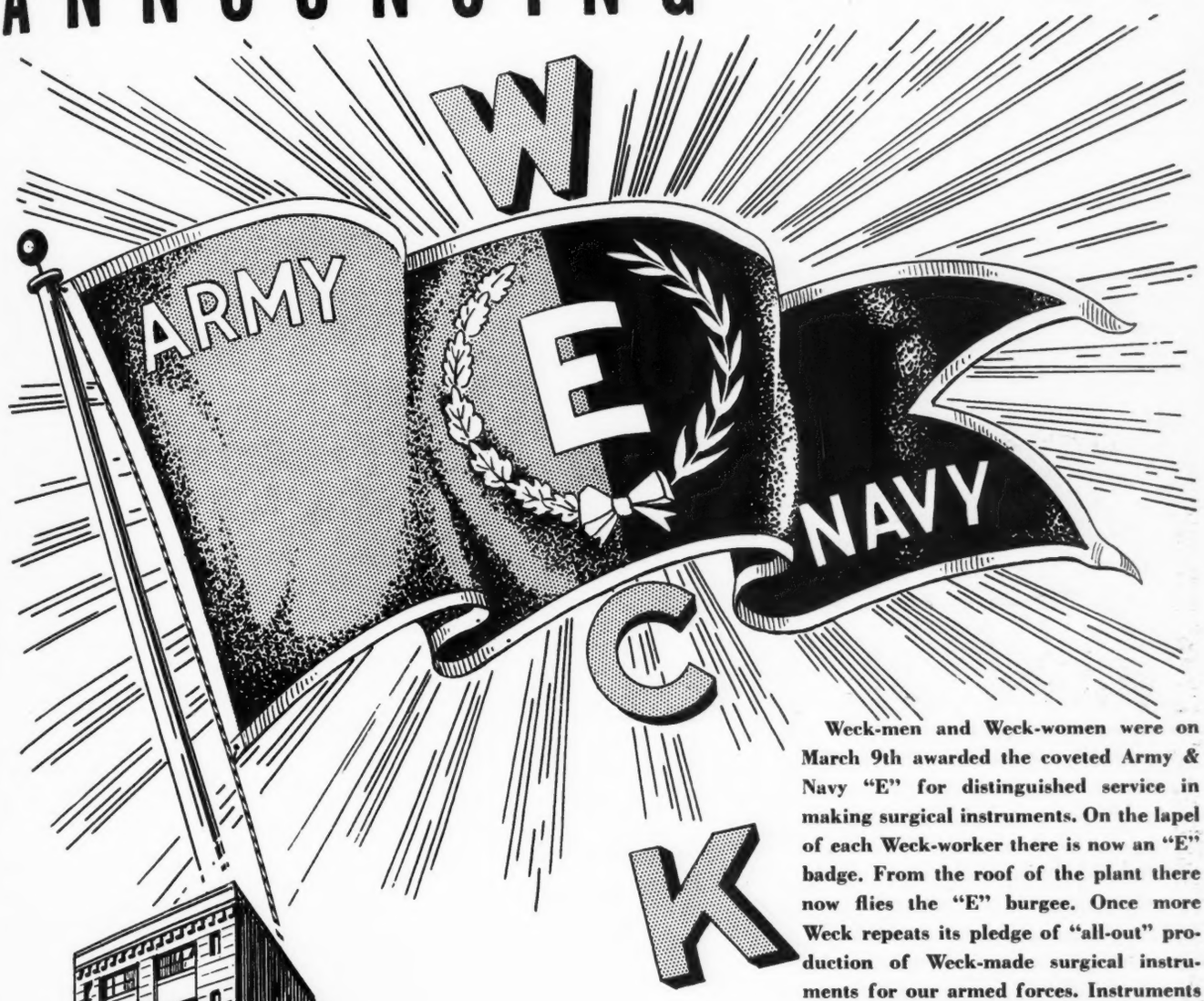
## A.H.A. Appoints Committee for Development of Purchasing

A committee for the regional development of purchasing has been appointed by the A.H.A. Council on Administrative Practice to foster the growth of a better understanding of purchasing—its problems and solutions.

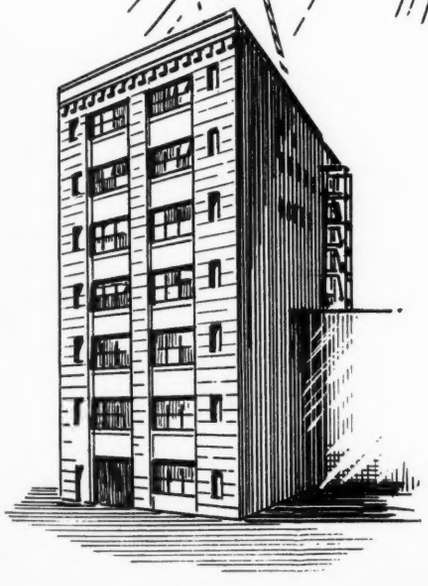
In order to accomplish its objective, the committee is working toward the inclusion of the subject of purchasing in all regional and national hospital associations and is arranging through individual state associations the inauguration of a purchasing group in each city that has several hospitals or each county or group of counties in areas in which hospitals are scattered. These groups will consist of hospital purchasing agents and administrators who do their own purchasing.

It is the feeling of the committee that group meetings will provide a medium for the exchange of ideas and information on problems of priorities, substitutions, shortages and rationing.

# ANNOUNCING ★ ★ ★




**Weck-men and Weck-women were on March 9th awarded the coveted Army & Navy "E" for distinguished service in making surgical instruments. On the lapel of each Weck-worker there is now an "E" badge. From the roof of the plant there now flies the "E" burgee. Once more Weck repeats its pledge of "all-out" production of Weck-made surgical instruments for our armed forces. Instruments which conform to the rigidly-high standards of craftsmanship demanded by the Army and Navy engineers.**



Founded 1890


## Edward Weck & Co., Inc.

**Manufacturers Surgical Instruments**

*SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES*

135 Johnson Street

Brooklyn, N.Y.

## Baltimore Hospitals Start Labor Stabilization Program

(*Continued from page* 49)

protected to a similar extent. The regulations of W.M.C. do not freeze persons in jobs but employes must obtain releases from their employers or from W.M.C. before transferring. Twenty-three hospitals had signed the agreement up to April 15.

W.M.C. is receptive to the suggestion that whenever an advisory board is established the hospitals be represented, according to a statement on March 30 from James R. Clark, director of the A.H.A. Wartime Service Bureau. Mr. Clark did not indicate whether this means a national advisory board or local boards.

Paul V. McNutt, chairman of W.M.C., on April 18 urged employers to use registered aliens who are not yet being used most effectively. In most industries, including hospitals, an alien may be hired as simply as an American citizen. Procedures for obtaining clearance for an alien have been shortened and simplified.

Officials of the War Relocation Authority are also trying to find positions in the noncoastal areas for Japanese evacuees, especially those who are American citizens. Many of them are college graduates and have great skill. They want a chance to demonstrate their loyalty to the United States. All are fully investigated before they are relocated.

The War Relocation Authority does not want these Japanese to settle in a hostile environment or to accept less than prevailing rates of pay.

## Added Protection for Civilians Given by New O.C.D. Radio Service

WASHINGTON, D. C.—War Emergency Radio Service, a new system of two-way radio communication for the use of civilian and other defense forces in local areas, has been set up by the Office of Civilian Defense and the Federal Communications Commission.

WERS has been assigned a number of frequencies by the F.C.C., the more important being from 112 to 116 megacycles. Within this range it has been recommended that operation be planned for three bands of several channels each. One band connects the local civilian defense control center with the district control center; a second connects the local control center with fixed points, such as wardens' posts, hospitals and public utilities, and a third connects mobile forces like emergency medical teams and fire trucks with the control center. This third band can also be connected with walkie-talkie equipment.

WERS transmitters have an effective communicating range of approximately 10 miles. The system can reach many points simultaneously, it can reach defense forces in motion and it is available when other methods of communication have been put out of action.

For hospitals, particularly, the O.C.D. points out, WERS represents a communication asset that can be valued in terms of lives saved. If telephone communication is destroyed the control center can still keep a complete picture of the hospital situation by WERS.

By use of the system ambulances can be loaded and dispatched effectively because the control center is in communication both with hospitals and with the incident officers. If the hospital facilities of one area become overtaxed, the radio channel to the district headquarters can arrange for reenforcements.

### Convert to Coal, W.P.B. Warns

WASHINGTON, D. C.—Eastern hospitals that use fuel oil were warned again in April that they should, if at all possible, convert to coal as soon as the present heating season ends. In case of physical or financial difficulties that make conversion impossible or involve great hardship, hospitals will be given the same consideration as they received last winter.

## OFFICIAL ORDERS
### March 15 to April 15

W.P.B. ORDERS

**Commercial Dishwashers.** — Manufacture of simplified models of commercial dishwashers up to 25 per cent of the weight of metal used in 1941 permitted through order L-248.

**Cooking Equipment and Dishwashers.**—Hospitals must use the new form PD-638-A when applying for commercial cooking and food and plate warming equipment and commercial dishwashers. Forms available at suppliers, regional W.P.B. offices and in Washington; can be identified by date, 3-1-43.

**Electric Fans.**—Maintenance of portable electric fans assured through amendment of order L-176, on April 6, permitting limited manufacture of certain repair and replacement parts. New parts deliverable only when similar old parts are exchanged. Fans now frozen can be released only with W.P.B. authorization, generally granted for civilian or military hospital use. "Electric fan," as defined, covers wall propeller fans having a blade diameter of less than 17 inches and ceiling fans.

**Household Refrigerators.**—Some 400,000 household refrigerators, 150,000 of them electric or gas operated, available for civilian use. Gas and electric types to be sold only to those who cannot use nonmechanical types. Everett Jones advises hospitals needing domestic refrigerators to apply immediately to local dealers to see whether they can be sold to hospitals. If not, then hospitals must file form PD-427.

**Metal Windows.**—Restrictions on completely fabricated metal windows removed March 19. Of 150,000 such windows now in dealers' or manufacturers' inventories most are of residential type. Order permits manufacture without a rating of metal storm windows from material partially fabricated prior to issuance of order.

**Paper Products.**—Amendment, April 7, to General Conservation Order M-241-a permits manufacture of table covers (all types), doilies, mats and tray covers, shelf and drawer lining paper up to 60 per cent of 1942 production; paper napkins and towels up to 95 per cent.

**Refrigeration and Air-Conditioning Equipment.**—Limitation Order L-126, amended March 27, restricts self-contained drinking water coolers to 5, 10 and 20 gallon marine-type coolers; permits production of certain types of water-cooled condensing units for specific uses; reduces number and sizes of refrigeration valves, fittings and accessories; restricts number of commercial reach-in refrigerators to four sizes and walk-in type to nine sizes. Use form PD-831 not PD-1A for commercial refrigerators; use PD-427 for domestic refrigerators.

**Wheel Stretchers, Examining Tables and Bassinets.**—Revisions to Order M-126, April 8, permit wheel stretchers and adjustable examining tables to be made entirely of steel; also permit isolation cabinet type of bassinet and functional parts for combination bedside tables.

O.P.A. ORDERS

**Cost of Living Items.**—Regulations are being prepared by O.P.A. to put price ceilings on wheat, cotton, fresh fish, fresh fruits, certain oil-bearing seeds, milk for manufacturing purposes, and certain other products.

**Lubricating Oil.**—On April 14, used and rerefined lubricating oil exempted from the fuel oil rationing regulation to encourage its use as a substitute for the heavy types of fuel oil in industrial heating and processing.

### "C" Ration Extended

WASHINGTON, D. C.—Virtually all types of installation, maintenance and repair service on essential nonportable goods were made eligible for "C" gasoline rations effective March 20 by amendment No. 35 to Ration Order 5C. The amendment lifts the restrictions which gave such preferred mileage only for performing structural or mechanical installation, maintenance or repair services by striking out the words "structural" and "mechanical."


IT'S easy to be in over your head these days. Fact is, temporarily, none of us are functioning in our natural element. In a good cause we're fumbling around in a maze of self-imposed restrictions. ☆ Don't let it sink you. When you have that submerged feeling and begin to wonder if it's ever going to be possible to get the supplies you need for adequate war-time service—ask Will Ross. ☆ It's our business to get down to the bottom of things, so hospitals may continue to function effectively.

# WILL ROSS, *Inc.*

MILWAUKEE
WISCONSIN

*Quality Hospital Supplies*

*18 Specialized Departments* ☆

Surgical Dressings
Sutures • Instruments
Needles • Syringes
Thermometers
Rubber Goods
Hospital and Laboratory Glassware
Surgical Glassware
Enamelware
Linens • Garments
Traywares
Paper Goods • Lamps
Tuberculosis Sanatorium Supplies
Maternity Supplies
Furniture
Equipment for Surgery and Operating Room
Smallwares and Specialties

## New York Hospitals Rally to Meet the Impact of War

(*Continued from page 57*)

Mr. Kaempffert sees neither in the Beveridge Report nor in the plan advanced by our National Resources Planning Board anything to imply the abolition of the voluntary hospitals.

Also speaking on the subject of the future of the voluntary hospital, Arthur A. Ballantine, vice president, United Hospital Fund, and president of the Greater New York Fund, indicated that it would be an "irreparable loss" if government hospitals should take over the services of the voluntary hospitals which had their origin and still draw much of their support from private benefactions.

"Aside from the practical 'yardstick' value of maintaining such voluntary hospitals," he said, "no thoughtful person would deny the individuals on the home front personal participation in the relief of physical suffering and in giving that relief or would limit the scope in that field for the forces of religion and brotherhood that live in these voluntary hospitals."

Some idea of what is required in the preparation for the return of the sick and wounded was given by Brig-Gen. Norman Thomas Kirk, Percy Jones General Hospital, Battle Creek, Mich. Some 44 general hospitals each with a bed capacity of from 1000 to 3000 are now caring for the casual sick as a result of disease or injury during the training period of the Army at home, plus the casual sick from overseas bases and battle casualties from Hawaii, the South Pacific and North Africa.

Certain general hospitals, according to General Kirk, have been designated as debarkation or port hospitals on the Atlantic, Pacific and Gulf coasts where casual sick and battle casualties will be first hospitalized after their return from overseas by hospital ship or transport.

The construction of additional general hospitals by the acquisition of buildings for conversion or by construction of temporary or semipermanent-type buildings to meet the needs of returned sick and wounded is now under way. The enlisted strength of the medical department initially consisted of 8000 men, he continued, and now totals 250,000.

Following is a complete list of the subjects and speakers: "Methods of Providing Medical Personnel for the Armed Forces, Civilian Hospitals and the Community," Dr. Harvey B. Stone, discussed by Dr. David P. Barr, professor of medicine, Cornell University Medical College, and Dr. J. R. Clemmons, director, Roosevelt Hospital, and chairman, New York State Office of Procurement and Assignment; "War-Time Difficulties of Providing Adequate Hospital Service," John H. Hayes, discussed by John F. McCormack, superintendent, Presbyterian Hospital; "Postwar Medicine and Hospitals," Waldemar Kaempffert; "The Loss of Nursing Personnel and the Problem of Replacement," Margaret E. Conrad, discussed by Sister Loretto Bernard, superintendent, St. Vincent's Hospital; "Medical Social Service in War Time," Mrs. Edith G. Seltzer, consultant on medical social service, United Hospital Fund, discussed by Dr. Thomas D. Dublin, associate professor of preventive medicine and community health, Long Island College of Medicine; "Social Services in Britain," Ruth Taylor, commissioner of public welfare, Westchester County, discussed by Clare M. Tousley, director, Department of Public Interest, Community Service Society of New York; "Catastrophe on the Home Front," Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital, discussed by Dr. Edward M. Bernecker, commissioner of hospitals for the city of New York; "Preparation for Control of War-Time Epidemics Among Civilians," Dr. Ernest Lyman Stebbins; "Preparation for the Return of the Sick and Wounded," Brig.-Gen. Norman Thomas Kirk, and "The Future of the Voluntary Hospital," Arthur A. Ballantine.

# Myxedema

NOT so many years ago frank myxedema was a very mysterious disease. But today its relationship to advanced thyroid deficiency is firmly established. A multitude of individuals have been transformed from lethargic unfortunates into alert, productive citizens through the medium of thyroid medication.

In the preparation of THYROID "ARMOUR" the selected animal glands are chosen carefully by geographic areas where a relatively stable proportion exists between thyroxin and the other organic iodine compounds. The desiccated glands are assayed and then blended to fixed standards—a method also devised by The Armour Laboratories, and made possible by Armour's tremendous supply of raw material.

Nowadays, the less marked degrees of thyroid deficiency are encountered much more frequently than is frank myxedema. But regardless of whether you are treating an incipient or advanced thyroid deficiency, uniformity and dependable potency of medication are of paramount importance. For this reason it is sound practice to *always* specify "ARMOUR" whenever ordering thyroid.


**Thyroid Armour is supplied in 1/10, 1/4, 1/2, 1, 2 and 5 grain tablets—either plain or enteric coated, and in powder.**

## ARMOUR LIVER PREPARATIONS

In the manufacture of liver preparations as in thyroid preparations, The ARMOUR LABORATORIES has available the world's largest supply of fresh raw material. Therefore it is possible to employ only the carefully selected livers of young, healthy, actively growing animals in the manufacture of Armour liver preparations. Armour scientists and technicians are skilled in judging, handling and processing of animal products. These are some of the reasons why the name "ARMOUR" has come to stand for "excellence" in liver preparations.

**THE ARMOUR LABORATORIES • CHICAGO, ILL.**
**Headquarters for Medicinals of Animal Origin**

**Liver Liquid (Parenteral) Armour**
**4 U. S. P. Units** (injectable) per cc. in 1 cc., 5 cc., and 10 cc. rubber-capped vials.
**10 U. S. P. Units** (injectable) per cc. in 1 cc., 5 cc., and 10 cc. rubber-capped vials.
**15 U. S. P. Units** (injectable) per cc. in 1 cc., 5 cc., and 10 cc. rubber-capped vials.

**Solution Liver Extract (Oral) Armour**
45 cc. equal 1 U. S. P. Unit (Oral)

**Liver Extract Concentrate Capsules (Glanules).** Each capsule contains 0.5 gram Liver Extract Armour suspended in neutral base. 9 capsules equal 1 U. S. P. Unit (Oral).

## Army Nurses Promoted; Age Limit for Corps Raised to 45 Years

EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The promotion of 16 captains in the Army Nurse Corps to the grade of lieutenant colonel and 15 captains to the grade of major, as announced by the War Department April 3, represents the first time so many Army nurses have been promoted to field grades.

Among those now wearing the silver oak leaf of a lieutenant colonel are the former captains of the nine Service Commands.

Also promoted were Capt. Nellie V. Close, director of the nursing service, Army Air Forces; Margaret E. Aaron, in charge of the nurses in Britain; Mrs. Martha J. Clements, in charge of the nurses in Australia, New Guinea and New Caledonia; Pearl Fisher, formerly of the Surgeon General's office, Washington; Elsie Neff, 67th Hospital, Denver; Lida E. Rassenberger, Lawson General Hospital, and Lyda Keener, Walter Reed Hospital.

An additional lieutenant colonel will be named to serve as principal assistant superintendent of the Army Nurse Corps when Lt.-Col. Florence A. Blanchfield, acting superintendent, succeeds to the superintendency upon expiration of Colonel Flikke's terminal leave. Many first lieutenants were promoted to captain, heretofore the highest grade that Army nurses, with the exception of the superintendent and assistant superintendent, might attain.

Thirty-seven Army nurses, including several who served in Bataan, have been selected from the various service commands to take part in the campaign to recruit nurses for the armed forces, the goal of which is 2500 per month. The Army nurses are assigned to 37 major cities though they will visit other centers.

American-born Japanese nurses are now eligible for assignment with the Army Nurse Corps, according to a recent announcement of the War Department.

The age limit for the Army Nurse Corps has been raised to 45 to include the forty-fifth birthday. The age limit for the Navy Nurse Corps, however, still remains at 40.



## New York State Health Council Adopts Rules on Blood Plasma Banks

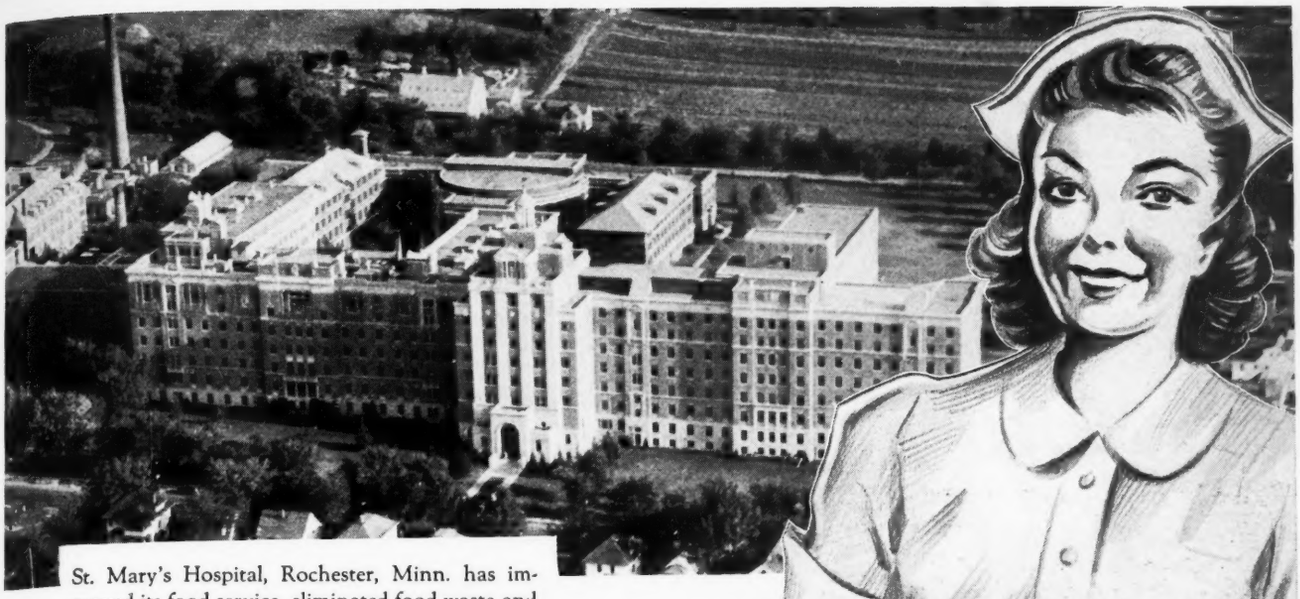
In order to obviate insofar as possible the dangers attendant upon blood or plasma transfusions, the New York State Public Health Council has adopted new regulations designed to meet the need for basic standards to ensure better protection of patients from infections in human blood or its derivatives. These regulations, which were embodied in the state sanitary code on March 1, are believed to be the first to be adopted by a state body.

Some of the provisions of the amendment are:

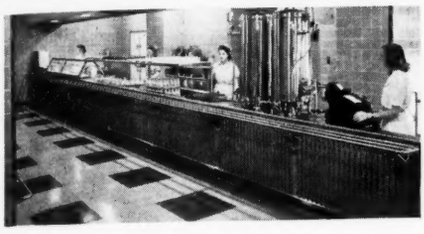
1. Laboratory tests required as an aid in determining that blood donors are free from communicable disease must be made in laboratories approved by the state commissioner of health, licensed by the Federal Security Agency or maintained by the Army, Navy, Veterans' Bureau or Public Health Service.

2. The laboratories or hospitals in which the blood is processed shall submit to the state commissioner of health a statement of the procedures used in the preparation, testing and storage of the product or products sold, distributed or offered for use.

3. Complete and accurate records of transfusions must be kept by the institution in which the transfusion is performed and the director or person in charge will be responsible for the proper maintenance of the records. These records are to be open to inspection by the state commissioner of health or his authorized representative.



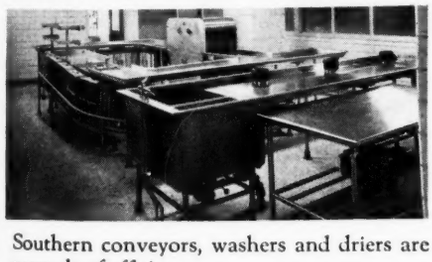
St. Mary's Hospital, Rochester, Minn. has improved its food service, eliminated food waste and reduced kitchen operating costs with a *"Custom-Bilt by Southern" simplified-centralized* kitchen.

Sanitation supplements efficiency in this all electric, automatically controlled counter.

Moving belt tray conveyor speeds foods from serving units to dumb waiters.

Roasting ovens, kettles, steamers, etc. are designed to improve food—reduce labor.



Southern conveyors, washers and driers are marvels of efficiency.

*The New Medical Unit of St. Mary's Hospital, Rochester, Minnesota,* now serves eight floors of patients' rooms, several dining rooms and cafeterias from a SINGLE Southern-designed *simplified-centralized kitchen.* Only two dietitians needed instead of eight. Food service improved 60%. Food waste reduced . . . important savings effected in operating costs.

Southern *simplified-centralized kitchens,* available to hospitals at present under War Production Board restrictions, offer an important improvement in culinary service. We are making complete kitchen installations for Uncle Sam on war contracts —doing a 100% complete job from start to finish in our own plant.

We'll be glad to help you plan a *simplified-centralized kitchen* especially designed for utility, sanitation and compactness. A *"Custom-Bilt by Southern"* installation adds to efficiency—subtracts from operating costs. We invite your inquiries.

**Southern EQUIPMENT CO.**

**5017 SOUTH 38TH STREET ST. LOUIS, MISSOURI**

**OFFICES: DENVER - DALLAS - MIAMI - COLUMBUS - MOBILE**

## Hospitals Must Do Even Better Job, Speakers Tell Pennsylvania Group

The Hospital Association of Pennsylvania made its twenty-second annual meeting a war conference and, foregoing commercial exhibits and the annual banquet, its members took time to analyze critically their services and attitudes in the present emergency as well as in the postwar period.

"We need to reconsider ourselves, our methods, our viewpoints," said Joseph G. Norby, president, American College of Hospital Administrators. "There is demand for a broader, bigger job than has ever been done before by voluntary agencies. What individuals will not do in this respect the government will do."

These opinions were confirmed by other speakers, including James A. Hamilton, president, American Hospital Association, who voiced emphatically the need for more team fortitude or unity in hospital work, adding that what we are doing and thinking now will determine the future of our voluntary hospitals.

In the meanwhile there is little hope that problems facing hospital administrators will grow less, particularly as affecting manpower. Harry W. Benjamin, superintendent, Mount Sinai Hospital, Philadelphia, reported the results of a survey among 100 hospitals throughout the state. It showed a higher than normal rate of occupancy with a serious shortage of manpower. Seventy-eight hospitals revealed an acute shortage, averaging 17 per cent in nonprofessional help, with no prospect of filling these vacancies. All reported an exceedingly high rate of turnover, ranging between 100 and 200 per cent with replacements inferior to existing needs in quality and quantity. The public and the governmental agencies, according to Mr. Benjamin, are either unaware of or apathetic toward this critical health problem.

As a remedy to the problem of manpower, Harold T. Prentzel, president of the association, recommended the appointment of a presidential commission to survey existing hospital facilities and determine the need for additional hospital services; he urged recognition of hospitals as government war agencies with a directive from the War Manpower Commission declaring hospital services essential.

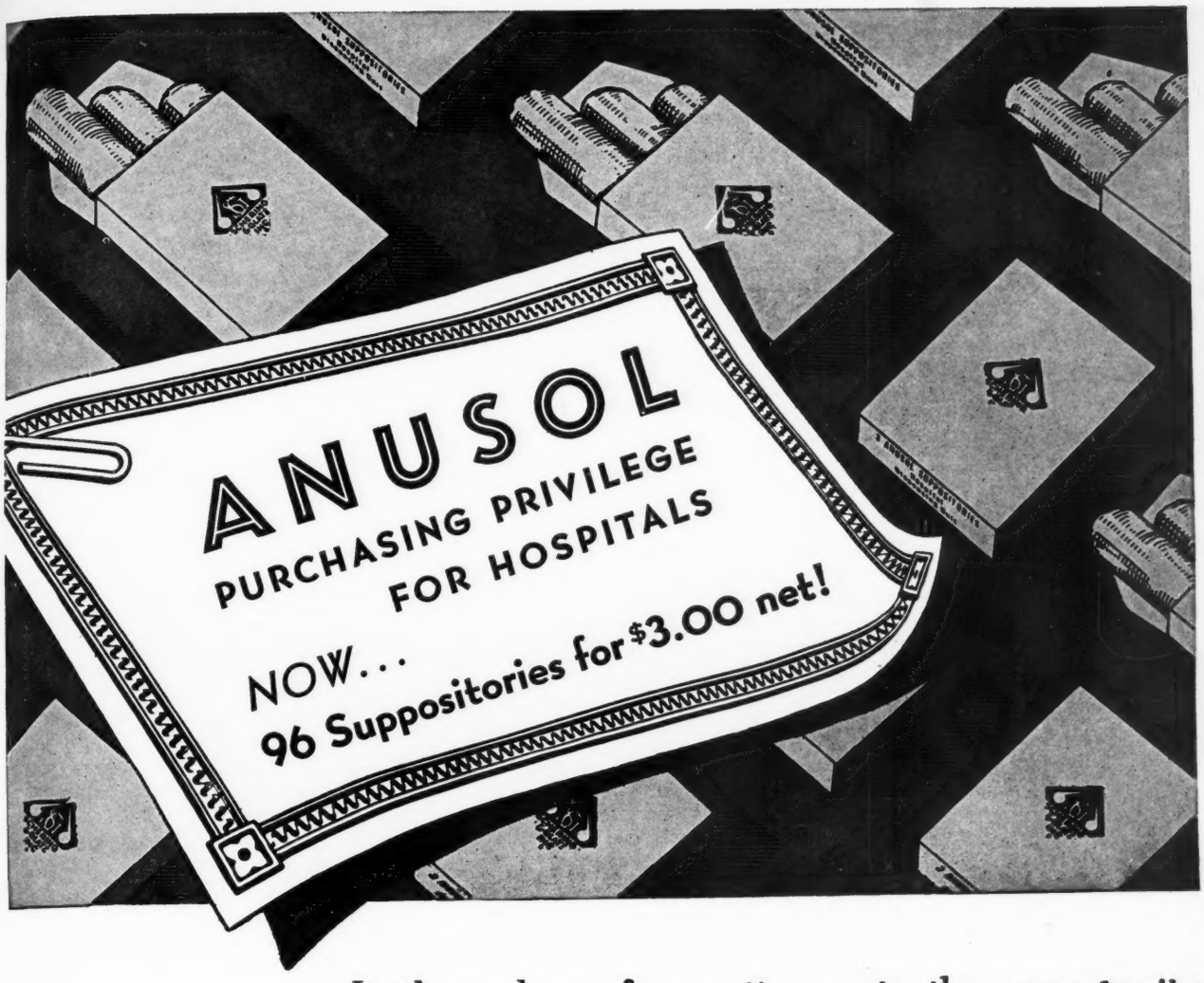
"Social insurance against the costs of hospital care is both desirable and practical" in the opinion of I. S. Falk, director, Bureau of Research and Statistics, Social Security Board. "By building upon the foundations of our present national social insurance system," he said, "the collection of contributions to cover the cost of hospitalization payments could be readily arranged without additional administrative machinery or cost."

Unanimously approved by the association was a resolution supporting House Bill 2326 which deals with student war nurse reserves.

What exhibit space was available was turned over to a display on nutrition and food values in war time designed to provide suggestions for the observation of National Hospital Day in hospitals throughout the state. This represented cooperative effort on the part of dietitians, the state nutrition council, state health officers and hospitals.

Of particular interest in the exhibit was an individual table setting shown with a glass of milk partly filled, a cup and saucer with sugar undissolved in the bottom of the cup formerly containing tea or coffee, a portion of a slice of bread, part of a pat of butter, leaves from a salad, a portion of potato and some meat left on a bone. The total cost of the foods wasted was displayed conspicuously with the ammunition or surgical supplies this would provide.

The retiring president, Harold T. Prentzel, was succeeded by Dr. Donald C. Smelzer, managing director, Germantown Dispensary and Hospital. Other officers are: president-elect, Raymond F. Hosford, superintendent, Bradford Hos-




In these days of mounting costs, the opportunity to buy an item at "bargain price" is doubly welcome, especially so if the offer concerns a professionally favored product such as Anusol Hemorrhoidal Suppositories. Each Hospital Package of Anusol, containing eight dozen (96) suppositories, is now priced at $3.00 net. A unique feature of this package is its subdivision into 32 individual cartons, each carton containing three suppositories, with space for directions on the cover, and convenient for dispensing.

This economical offer should bring Anusol Suppositories within the budget of all hospitals. The package can be supplied only to hospitals and institutions on direct order . . . the low price permitting no discount. Write for our Hospital Price List showing all the Schering & Glatz products available to hospitals.

**SCHERING & GLATZ, INC., 113 West Eighteenth Street, New York**

pital, Bradford; first vice president, Rt. Rev. Msgr. Leo Fink, Sacred Heart Hospital, Allentown, and second vice president, Albertina Six, Lewiston Hospital, Lewiston. Elmer E. Matthews, Wilkes-Barre General Hospital, continues as treasurer and S. Harley Armstrong, as executive secretary.

## Food, Personnel Problems Discussed by Kentucky Group

Members of the Kentucky Hospital Association meeting in Louisville April 8 and 9 were told by L. Edward Knapp, state representative of the O.P.A., that patients would get all the food they need but hospital personnel must abide by the same rationing rules as other civilians. Speaking at the closing session of the meeting, Everett W. Jones, head hospital consultant of W.P.B., warned hospitals against the abuse of the new AA-1 priority that has been granted them under CMP-5A.

Other speakers included James A. Hamilton, who advised hospitals that are forced to curtail their services because of shortage of personnel to seek the aid of the Washington Bureau, and Frances H. Ziegler, dean of Vanderbilt University School of Nursing. Miss Ziegler suggested as a partial solution of the nurse shortage problem the provision of better working conditions in terms of hours, salaries and living conditions.

New officers elected were: Rev. Thomas B. Ashley, Pikeville Hospital, Pikeville, president; Herman A. Cross, Jewish Hospital, Louisville, president-elect; Sister Ludovica, Sts. Mary and Elizabeth Hospital, Louisville, first vice president; S. A. Ruskjer, William Mason Memorial Hospital, Murray, second vice president, and H. L. Dobbs, Kentucky Baptist Hospital, Louisville, treasurer.



## Number of Hospitals Declines; Beds Added, A.M.A. Figures Reveal

Registered hospitals in the United States increased their bed capacity by 59,446 to a total of 1,383,827 beds and their bassinet capacity by 5285 to a total of 71,448 bassinets, according to the annual hospital survey published in the March 27 issue of the *Journal of the American Medical Association.*

The number of hospitals declined from 6358 in 1941 to 6345 at the end of 1942. Average occupancy of all hospital beds in 1942 was 81.4 per cent. The number of admissions reached a new high of 12,545,610, a gain of nearly a million over 1941.

The increase in hospital beds during 1942 was about two thirds of that for 1941, but gains in both years were far above the average for the last ten years. General hospitals gained 60,000 beds and nervous and mental hospitals gained 8000 beds, while hospital departments of institutions lost approximately 8500 beds.

### Emergency Kits for Sub Chasers

A drive for $25,000 to furnish special portable emergency kits to the 1000 submarine chasers of the Navy has been started by the Medical and Surgical Relief Committee of America, New York City. The committee has already shipped 13 kits to the Submarine Chaser Training Center in Miami, Fla., in answer to the growing demand for medical and surgical equipment for submarine chasers, which are not ordinarily staffed by medical officers. The kits, a foot square, are made of fiber board with metal edges.

In addition to the funds needed, the committee has appealed to surgeons, physicians and medical supply houses for drugs and instruments. Among the items requested are artery clamps, splinter forceps, scalpels, probes, grooved directors, sulfadiazine tablets, sulfadiazine ointment (5 per cent), sulfathiazole tablets and sterile shaker envelopes.

# Savory Saves!

## *in six different ways*

Victory minded buyers—for production, army, navy or marines—jealous of any purchases which may drain critical supplies—smile with approval on SAVORY TOASTERS. For SAVORY saves America's resources these ways:

**SAVES CRITICAL MATERIALS:** On basis of toast produced, SAVORY *contains far less critical materials* than any other toast-making appliance.

**SAVES SPACE:** SAVORY's compact rugged unit takes minimum room in kitchens, on counters, or in ships' galleys. *Turns out 360 to 600 slices per square foot of space per hour!*

**SAVES FUEL:** Electric or gas consumption is *far less* per 1000 slices *than any other method.*

**SAVES MANPOWER:** *Likewise labor costs.* Single attendant for big installations; intermittent attention from counter man on small units.

**SAVES TIME:** Model shown can produce four slices of hot, crisp, golden brown toast every twenty seconds. Larger models available.

**SAVES BREAD:** *No bread loss . . .* even three-day-old bread made deliciously palatable. No burned or underdone slices.

SAVORY savings are war winning economies. SAVORY savings pay for any installation in short order.

Today SAVORY TOASTERS help fighters and workers alike—in ship galleys around the world—at training stations—at naval bases—in hospitals—and in war production plants, hotels, restaurants, and institutions everywhere.

*For* SAVORY *specifications and prices write to your nearest equipment dealer or to*

# Savory
## EQUIPMENT

*a division of* TALON, INC.

**122 PACIFIC STREET, NEWARK, NEW JERSEY**


*Model CT-4, all-electric, 540 to 720 slices per hr. Gas models also available.*

## Simplify Furniture and Equipment of Operating Rooms, Officials Urge

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The Operating Room Furniture Industry Advisory Committee and officials of the W.P.B. met in Washington, according to an announcement on April 2, to discuss conservation and simplification measures applicable to equipment used in hospitals, physicians' offices, first-aid stations and clinics.

Submitted as a basis for further study was a report embodying specific recommendations on the manufacture of 70 items of operating room furniture and related equipment.

The report gave consideration to the essential use of each item, the need for current models in maintaining and promoting medical technics and the effect on health and safety of substituting wood and other nonmetallic materials for critical metals.

No restriction, the report held, should be imposed on the use of metal where such material was deemed necessary to avoid infection and contamination as, for example, examining and treatment tables and the tops and shelves of dressing trucks. In 19 items, metal was eliminated and the restriction of metal to wheels and hardware was recommended in 11 other items. Elimination of ball-bearing casters and wheels, wherever possible, was prescribed as was the exclusion of chromium and nickel plating except on moving parts, and of brass and copper bearing alloys except on vital parts of operating tables and incubators.

The subcommittee further recommended that reduction in the number of models and sizes could be most satisfactorily effected by permitting each manufacturer to continue to produce a limited number of the models and sizes he is currently making.



## Impetigo Cured in Day With New Form of Sulfathiazole

Using a 20 per cent suspension of microcrystalline sulfathiazole, Dr. T. N. Harris, Philadelphia, has been able to cure impetigo contagiosa in a single day and to stop the spread of the disease, it is reported in a recent issue of the *Journal of the American Medical Association.*

In his report, Doctor Harris points out that the development of a procedure that reduces the crystal size of sulfathiazole into microcrystals yields a stable suspension of fine crystals of sulfonamide and that the drug remains stable in pure water for many months.

Doctor Harris' technic of treating impetigo locally consists of the application of a small gauze dressing on which a drop or two of the suspension has been poured. It has been found that the water seeps into the gauze to a greater extent than do the crystals, leaving a concentration of sulfonamide crystals on the surface of the dressing.

Washing the area with soap and water, with removal of all crusts, is the only preparation necessary. One small dressing is applied to each lesion. Twenty-four hours later the lesion is healed.

### Tri-State Speakers Named

Talks on food rationing by O.P.A. officials will open the fourteenth annual meeting of the Tri-State Hospital Assembly in Chicago, May 5 to 7. Archie Palmer, deputy chief of the food rationing branch, O.P.A., in charge of institutional rationing, and Frank J. Sloup, regional representative of the food rationing branch, will start the Wednesday morning session. Other speakers at the three day meeting will include Everett W. Jones, discussing priorities, and James A. Hamilton, whose topic will be "Maintaining Adequate Professional and Nonprofessional Personnel." Mr. Hamilton will also be the banquet speaker on Thursday night.

ANSWER: Blow . . . hard . . . into the mouth of the glass causing the card to tip. The nickel will then slide into the glass.

# It's a neat trick!

*TRY IT! Place a nickel on a calling card atop a glass. Without touching the card, drop the nickel into the glass. Answer above.*

And we know an even *neater* trick to do with glasses! Instead of a nickel, use *G. L. X.* . . . the magical *soapless* cleanser. Wyandotte G. L. X. washes glasses and silver sparkling-bright, leaves them spotless, filmless, smudgeless . . . *without any toweling at all!* That's not all!—G. L. X. does a remarkable job of detarnishing silver.

Wyandotte is a Houdini with dishes, too. Stacks of dirty plates and platters disappear fast when a Wyandotte Compound sails in. And as for *money* . . . you should see how Wyandotte can make it stretch . . . by doing more work with less materials!

If your dishwashing is done by hand, Wyandotte H. D. C. can speed the job all around. Its efficient, thorough action assures shining results from start to finish.

For dishwashing by machine, Wyandotte Keego Cleaner is the ticket! Free-rinsing, Keego holds its strength in solution . . . safeguards your equipment, keeps your budget looking bright.

Should your local water conditions demand a specially prescribed cleanser, call in the Wyandotte Man. He can supply you with a Wyandotte Compound built to meet your exact needs.

**Wyandotte**

*SERVICE REPRESENTATIVES IN 88 CITIES*

**WYANDOTTE CHEMICALS CORPORATION**

**J. B. FORD DIVISION • WYANDOTTE, MICHIGAN**

*• Wyandotte Chemicals Corporation consolidates the resources and facilities of Michigan Alkali Company and The J. B. Ford Company to better serve the nation's war and post-war needs.*

## Australia Provides Hospital Care for American Servicemen

WASHINGTON, D. C.—"Somewhere in Australia" a 10 story hospital has been provided by the Australian government, under the lend-lease agreement, for American soldiers, sailors and marines. Even before it was completed, the building, which had been started as a civic enterprise, was taken over and adapted for the American forces to accommodate several times its original capacity.

The hospital's equipment is especially suited for the treatment of fevers and jungle-bred illnesses.

The main buildings are well arranged and provide a maximum of quiet. Broad verandas for convalescents are supplemented by roof areas on which servicemen gather to relax in glass enclosed rooms or in the open air. Ping-pong tables and other recreational equipment are available to them here.

Exchange of supplies and materials between the United States and Australia, under lend-lease, affects several phases of the operation of the hospital. Many of the medical supplies manufactured by Australian firms and furnished as reciprocal aid contain ingredients furnished by the United States.

Reverse lend-lease in Britain was well demonstrated March 25 with the bestowal of a hospital train on the U. S. Army Medical Department in Britain. The hospital train, the first to be built in Britain for the United States, has six ward cars and a car for chair patients. It has a capacity of 300 wounded.



## O.C.D. Designs Pennants to Identify Emergency Vehicles

WASHINGTON, D. C.—A white pennant measuring 18 inches along each side and carrying a 6 inch basic civilian defense insigne has been designed by the O.C.D. as an identifying device for emergency vehicles during real or practice air raid alarms. The pennant is to be attached to the left front portion of the vehicle.

To identify such vehicles at night in regions in which blackout regulations permit the use of headlights, a mask has been devised to fit over the right headlamp. The design of the mask embodies a green "CD" insigne, 2½ to 3 inches in diameter.

Vehicles traveling under the orders of the armed forces; fire and police equipment; public utilities repair trucks, and vehicles in emergency service as defined by the state civilian defense authorities will be entitled to use the emergency identification.

## Dietitians' Refresher Course to Be Held at Columbia

A refresher course for dietitians will open at Teachers' College, Columbia University, on July 5 and continue through August 13. The course, offering observation and experience in the management of hospital food service, will be given cooperatively by Presbyterian Hospital, Montefiore Hospital and the U. S. Marine Hospital, New York City.

Students will register for this course, Institution Management s207G, and for Institution Management s151, which covers classes, conferences and clinics in each hospital. The credits obtained in these courses (four points for s207G and two points for s151) may be applied toward a master's degree.

Appointments to the course will be made by May 15. Further information can be obtained from Dr. Mary deGarmo Bryan, Teachers' College, Columbia University.

### A.H.A. to Meet in Buffalo

Buffalo, N. Y., will be host city to the 1943 American Hospital Association, it has been definitely announced by A.H.A. officials. Delegates will assemble at the Hotel Statler in time to start the meetings on Monday, September 13, and the sessions will run through Friday.


CONTAINING soothing lanolin of U.S.P. quality, Williams Lanolin Soap merits your consideration in cases of dry skin. Even without the lanolin, it would be an exceptionally bland soap—

**Uncombined alkali is virtually non-existent in Williams Lanolin Soap. It contains no dye or strong perfume. No fatty acids are present. Only finest grade oils are used—and in a way that precludes injurious rancidity.**

Subjected to high pressure, Williams Lanolin Soap is long-lasting, economical. Its rich, creamy lather rinses completely. With its delicate scent and tasteful wrapping, it avoids any suggestion of a "medicinal" soap. Rather, it appeals to patients as a fine complexion soap.

May we send you a full-size cake of Williams Lanolin Soap with our compliments? That's much the best way to learn its advantages. Just mail the coupon—there's no obligation whatever.

**The J. B. Williams Co., Dept. SB-06**
**Glastonbury, Conn.**
**Please send me a full-size cake of Williams Lanolin Soap.**

**Name**_____

**Address**_____

**City**_____ **State**_____

This offer is restricted to the medical and nursing professions. Please attach letterhead, card or other professional identification. Good only in U. S. A.

## Manufacturer Opens Publicity Campaign on Hospitals' Behalf

A campaign of public education on behalf of voluntary hospitals consisting of six full page advertisements in the *Atlantic Monthly* was started with the April issue by the American Hospital Supply Company.

Other advertisements will appear in the May, June, September, October and December issues. Enlargements of the advertisements will be provided to hospitals on request so that they can be displayed in the hospital or throughout the community.

The objective of the campaign, as stated by Donald B. Snyder, publisher of the *Atlantic Monthly,* is "to make the position of the voluntary hospital more impregnable, to preserve the freedom of action and the independence of ideals which are essential to its proper function in the community and to enlist in the hospital movement a greater measure of public understanding and support."

### Rochester Group Raises Rates

Private, semiprivate and ward rates were raised by members of the Rochester Hospital Council, Rochester, N. Y., on April 11 in an effort to meet rising costs. In addition, requests will be made by the council for increased fees from governmental agencies, compensation carriers and the Rochester Hospital Service Corporation. The new rates will add 50 cents a day to the cost of ward and private rooms; 75 cents to private rooms that cost the base rate of $6.75 per day, and $1 to private rooms that formerly cost $8 or more.

## C.M.P. Allotments Will Be Simplified, W.P.B. Announces

WASHINGTON, D. C.—A simplified plan for allotting controlled materials under the Controlled Materials Plan for hospital and other commercial construction costing less than $10,000 was announced on March 26 by W.P.B.

Regional offices can authorize such construction without consulting Washington. A simplified PD-200-c form applicable to these cases is used. This form, which is an application for priority assistance or an application to begin construction without priority assistance, requires submission of a list of the materials that will be needed.

The forms are filed with the W.P.B. district office and then go to the regional office which makes allotment of controlled materials and assigns preference ratings on CMP-L-127 forms.

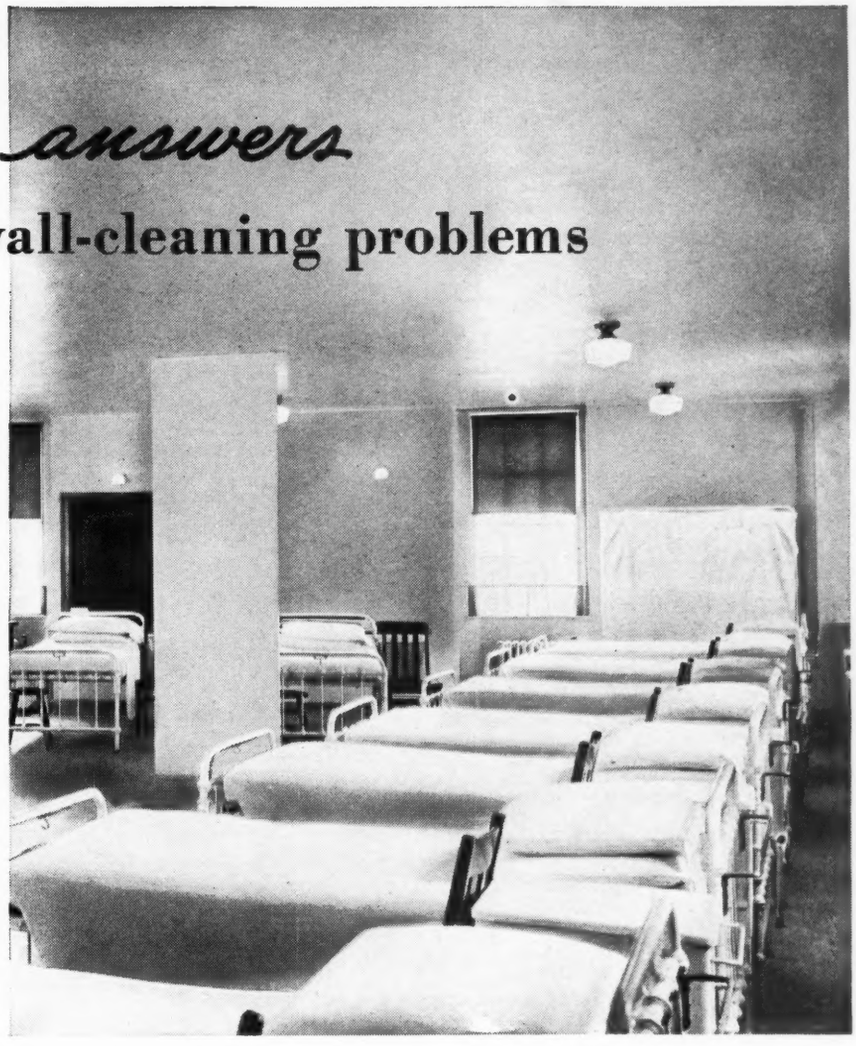
### Philadelphia Plan Pays $6,000,000

A check that brought the hospital payments from Associated Hospital Service of Philadelphia past the $6,000,000 mark was presented to Montgomery Hospital, Norristown, Pa., late in February. The 66 hospitals cooperating with the plan have received $5,361,467.74 of the total remittances during the last eight years and the balance of $665,126.97 has been divided among all other institutions that have hospitalized subscribers—inside and outside the United States.

### Army-Navy "E" Awards

WASHINGTON, D. C.—Between March 15 and April 15 the following firms serving the hospital field were awarded the Army-Navy production pennant: Armour and Company, Union Stock Yards, Chicago; General Ceramics and Steatite Corporation, Plant 3, Keasbey, N. J.; Allegheny Ludlum Steel Corporation, West Leechburg, Pa.; Don Baxter, Incorporated, Glendale, Calif.; Dahlstrom Metallic Door Company, Jamestown, N. Y.; M & R Dietetic Laboratory, Inc., Columbus, Ohio, and Parke, Davis & Company, Bay Division, Bridgeport, Conn.; Barnhardt Manufacturing Company, Charlotte, N. C. (Parent Company of Carolina Absorbent Cotton Company).

# 3 answers to hospital wall-cleaning problems



## PAINTED PLASTER

**Q.** *How can streaking be prevented when washing painted plaster?*

**A.** There are several precautions to take: Be sure to keep the sponge squeezed of excess cleaning solution* when applying. Use smooth, even strokes and work from the bottom up. Clean just a small portion of the wall at a time and rinse thoroughly with clear water.

## WOODWORK

**Q.** *Is there any way to preserve the glossy finish of painted and enameled woodwork despite frequent washing?*

**A.** Care should be taken that the paint or enamel itself is not scrubbed away. A sheep's wool sponge is recommended for applying the cleaning solution*. It is important to rinse the surface thoroughly with clear water and a clean sponge. Buffing with a soft cloth does much to restore gloss.

## MARBLE

**Q.** *Is there a special cleaning method that will protect the finish of polished marble?*

**A.** Yes. Before applying the cleaning solution*, dampen the surface of the marble. This pre-dampening fills up the pores, preventing any foreign materials from entering, crystallizing and thus injuring the finish. (Note: Any water used on marble should be softened.)

**Recommended cleaning solutions*

For the careful cleaning required for painted plaster, enameled and painted woodwork and marble... Armour has developed HOSPITAL GREEN SOAP and LIQUID SCRUB SOAP. Both are made from a neutral vegetable fatty acid base... contain no alkalis or abrasives. LIQUID SCRUB is preferred by many hospitals because its convenient liquid form saves time and labor. HOSPITAL GREEN comes in paste form.

When application is by hand, Armour recommends the following solutions:

2-4 ounces of HOSPITAL GREEN SOAP dissolved in 2 gals. of water.

¼-½ cup of LIQUID SCRUB SOAP mixed with 2 gals. of water.

### What Armour quality means to your hospital—in wartime

Now when your property and equipment must last — yet continue to be subject to constant cleaning and scrubbing — the quality of Armour's cleansing agents is even more important. Armour chemically analyzes all raw materials, and controls from the laboratory every manufacturing step to assure you of uniform, high efficiency *plus maximum safety.*

To take care of all your hospital cleaning needs, Armour makes 21 different products, including dainty hand soaps for patients and staff. An Armour representative will be pleased to show you how this complete line of cleansing agents can fill your wartime needs with the utmost satisfaction.

*Armour Cleaning Agents are available in quantities to fit your needs.*

WATCH FOR MORE CLEANING TIPS IN THESE ARMOUR ADS

**FOR WALLS**

| | |
|---|---|
| HOSPITAL GREEN SOAP | 50 lb. tub; 200 and 400 lb. barrels |
| LIQUID SCRUB SOAP | 30 and 55 gal. drums |

**Armour and Company** • *Industrial Soap Division*

1355 WEST 31ST STREET • CHICAGO, ILLINOIS

## Five Story Structure Adds 50 Beds to Epworth Hospital

Epworth Hospital, South Bend, Ind., added 50 beds to its capacity with the opening early in April of a new $226,000 addition. The new building, constructed of red brick to match the existing structure, is five stories high. Three of these, the second, third and fifth, comprise private and semiprivate rooms, and the fourth floor houses the obstetrical department.

A feature of the new section is the courtesy rooms which are for private consultations between physicians and patients' families.

Most of the cost of the addition was financed by a $176,000 Lanham Act grant, the remainder being obtained from local sources. A number of patients' rooms were furnished as memorial gifts by friends of the hospital.

## Men Volunteers Serve at Strong Memorial Hospital

Sixty men volunteers offered their services to Strong Memorial Hospital, Rochester, N. Y., on April 7 to act as orderlies, clerks and maintenance men. The volunteers, including bankers, school principals, ministers, brokers, salesmen, insurance men, premedical students and factory workers, answered the hospital's call for enrollees in the Men's Volunteer Corps to relieve the serious personnel shortage.

The men, who will be required to work a minimum of three consecutive hours weekly, have been given basic instruction in patient care, demonstrations in bed making and some of the principles of medical aid. They will receive a total of twenty hours of training, part of it with actual work experience on the wards.

The corps is being sponsored by the Associated Alumni of the University of Rochester and about 40 of those who reported are graduates of the school.



## Wilinsky Gets Civic Medal

Dr. Charles F. Wilinsky, director, Beth Israel Hospital, Boston, and chief medical officer of the Boston committee on public safety, was given the Civic Award Medal of the Boston City Club on April 12. This medal is presented each year to the citizen adjudged by the club to have rendered the most outstanding civic service to Greater Boston. In accepting the medal, Doctor Wilinsky stated that the Cocoanut Grove disaster proved that Boston has adequate medical and allied resources to cope with any emergency. "Hospitals were prepared to cope with the disaster because of the emphasis which had been placed on preplanning to meet potential enemy action."

## Andres Heads Kansas Group

Herman J. Andres, administrator of Bethel Deaconess Hospital, Newton, was chosen president of the Kansas State Hospital Association at its annual meeting in Wichita on March 2. Sister Mary Victoria of Wichita Hospital is the new secretary-treasurer. Approximately 100 hospital administrators and trustees attended, including an automobile full of trustees from Clay Center who drove 150 miles in a snowstorm to be present. James A. Hamilton, president of the A.H.A., inspired the delegates with a strong plea for the maintenance of the voluntary hospital system.

## Coming Meetings

May 3-4—Carolinas-Virginias Hospital Conference, Roanoke, Va.
May 5-7—Tri-State Hospital Association, Palmer House, Chicago.
May 10—Mississippi State Hospital Association, Heidelberg Hotel, Jackson.
May 23-25—Minnesota Hospital Association, Nicollet Hotel, Minneapolis.
May 26-28—New York and New Jersey Hospital Association, Hotel Pennsylvania, New York City.
June 12-14—Catholic Hospital Association, William Penn Hotel, Pittsburgh.
June 15-17—National League of Nursing Education, Chicago.
Sept. 13-17—American Hospital Association, Hotel Statler, Buffalo, N.Y.
Oct. 12-14—American Public Health Association, New York City.

## NAMES IN THE NEWS

### Administrators

**W. W. Smith** has assumed the duties of superintendent and business manager of Alice Hyde Memorial Hospital, Malone, N. Y., succeeding **Mrs. Mae G. Turner,** who resigned. **Isabel N. Reardon** is the new assistant superintendent and director of nurses. She replaces **Mildred Morrison,** who retired from the hospital recently.

**Dr. Gordon M. Meade,** administrative assistant of Strong Memorial Hospital, Rochester, N. Y., has been transferred to the department of medicine. Doctor Meade has been replaced by **Dr. John A. Lichty,** assistant professor of pediatrics in the hospital.

**Frank L. Bosquet,** formerly assistant director of Cleveland City Hospital and administrator at Waltham Hospital, Waltham, Mass., has recently accepted a position as assistant director of Salem Hospital, Salem, Mass.

**Sister Francis De Chantal** is the new superintendent of St. Joseph's Hospital, Mount Clemens, Mich., replacing **Sister Ann Teresa.**

**Mrs. W. J. Revell, R.N.,** has recently accepted the post of superintendent of Mississippi Baptist Hospital, Jackson, Miss.

**Frances E. Dalton** has been named acting head of Leonard Hospital, Troy, N. Y., to succeed the former superintendent, **Palma Ferraro.**

**F. E. Kassner,** formerly associate director of Michael Reese Hospital, Chicago, has assumed the duties of superintendent of Springfield City Hospital, Springfield, Ohio.

**Dr. R. R. Piper** became administrator of Detroit Receiving Hospital in March, succeeding **Dr. D. M. Morrill.**

**Warren H. Myers,** formerly cashier of the Northampton National Bank of Easton, Pa., was recently appointed assistant superintendent of Easton Hospital.

**P. R. Styring** has been named administrator of Stetson Hospital, Philadelphia, succeeding **Arthur H. Brittingham,** who is now head of Northeastern Hospital, Philadelphia. Mr. Styring resigned as assistant secretary of the Morris Plan Bank of Philadelphia to take over the Stetson Hospital post.

**Robert B. Witham,** former head of Leahi Home, Honolulu, T.H., has accepted the position of superintendent of the Kapiolani Maternity Hospital in Honolulu.

**John Crane,** at one time head of the American Hospital in Britain, is now associated with Montefiore Hospital, New York City, in the capacity of administrative assistant.

### Department Heads

**Bertha L. Knapp,** director of the school of nursing at Wesley Memorial Hospital, Chicago, since 1908, will retire September 1.

### Deaths

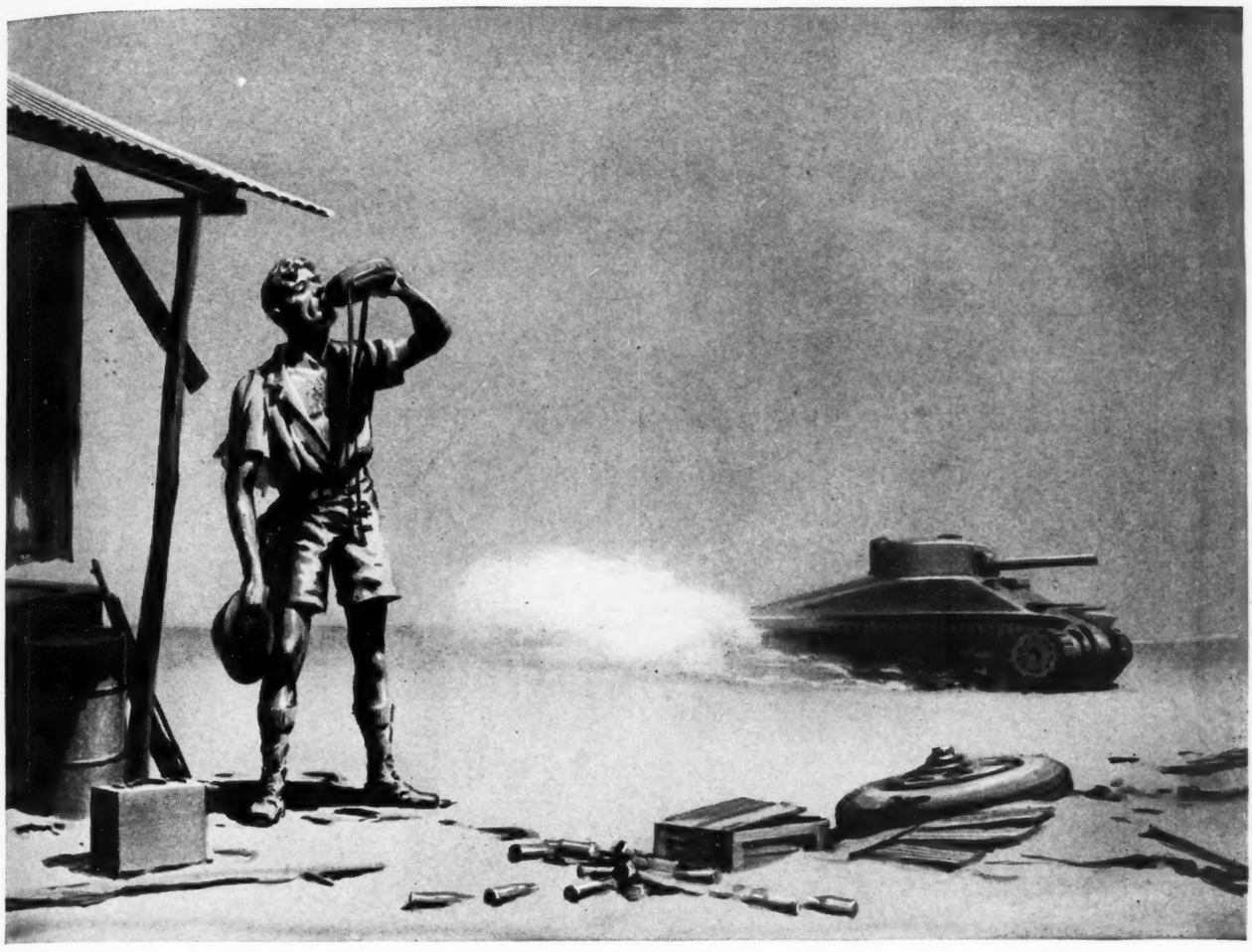
**Pvt. Robert Austin,** son of Capt. and Mrs. L. C. Austin, was killed in action while on duty with the 6th Marine Corps "somewhere in the Pacific." Private Austin's father is superintendent of Menorah Hospital, Kansas City, Mo., and was granted a leave of absence in December to serve in the medical administrative corps of the Army.

### Miscellaneous

**Dr. William J. Tiffany,** New York state commissioner of mental hygiene since 1937, resigned that position on April 1.

**Dr. Ellen C. Potter** has retired as acting president of the Woman's Medical College of Pennsylvania, Philadelphia. Doctor Potter was secretary of the state department of welfare during the administration of Gov. Gifford Pinchot.

**John F. Barker,** business manager of Watson Clinic, Brookings, S. D., will become superintendent of Dixie Hospital, Hampton, Va., on May 3.



# VALUE DEPENDS ON THE OCCASION

• *Circumstances determine values. Water is priceless on the desert, Lend-Lease materials are worth more at Murmansk than in mid-Atlantic and plasma can make the difference between living and dying only when it is available for administration.*

The value of 'Lyovac' Normal Human Plasma is always assured because this preparation is *stable*, *portable* and *practical*.

Each unit provides the osmotically active proteins as well as the antibodies, complement and other life-giving elements present in 250 cc. of fresh human plasma obtained from 500 cc. of whole blood.

Stability is obtained by quick freezing, followed by dehydration and storage under vacuum in flame-sealed glass vials. The desiccated plasma is simply restored by addition of sterile, distilled water. Hypertonic (concentrated) solutions can be easily prepared.

Stable, portable 'Lyovac' Normal Human Plasma can be kept safely without refrigeration wherever treatment of shock may be required . . . in accident room or ambulance, operating room, delivery room or office, in first-aid stations and mobile disaster units.

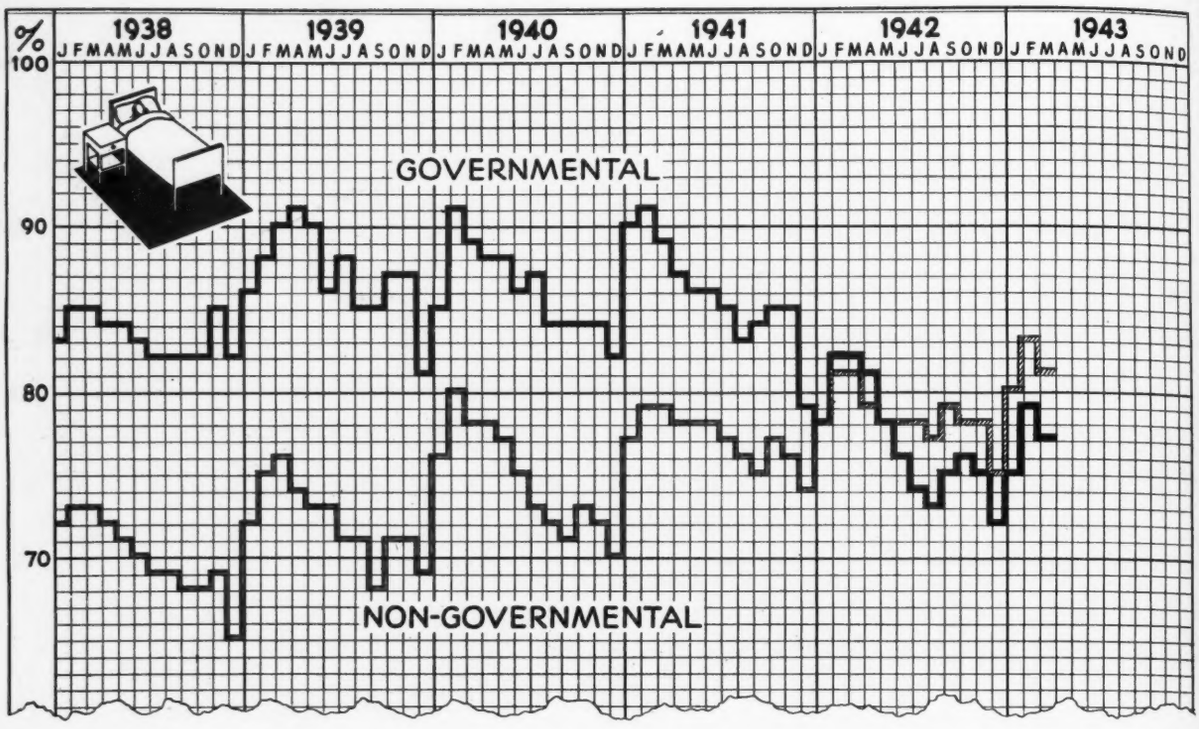
Each 250-cc. unit provides approximately as much osmotically active protein as 500 cc. of whole blood, and—since 'Lyovac' Normal Human Plasma represents pooled material from fifty bleedings—it may be administered at once without typing or cross-matching.

• • •

'Lyovac' Normal Human Plasma is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Each unit includes distilled water and complete apparatus for restoring the desiccated material. Sharp & Dohme . . . Philadelphia, Pa.

## 'LYOVAC' NORMAL HUMAN PLASMA

## Occupancy Figures Show Slight Drop




Occupancy in both governmental and nongovernmental general hospitals dropped two points in March. For nongovernmental hospitals, the March figure exceeded all preceding March records except 1942. For governmental general hospitals this was the lowest March on record.

Twenty-eight new hospital construction projects were reported last month with costs of $13,710,000, bringing up to $53,174,144 the total for 1943. Projects postponed since January 1 cost $16,039,610, leaving a net for the year to date of $27,134,000.